

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 5 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 1 month, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County PG
City or town Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt. #1, Box 261
(If rural, give LOCATION)
2. (a) If veteran, name war WWII

3. (a) FULL NAME

ADAMS, Clarence Lee

3. (b) Social Security Number

4. Sex male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mrs. Gladys Adams
6. (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) November 30, 1914

8. AGE: Years 33 Months 8 Days 13 If less than one day hrs. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual occupation Truck driver

11. Industry or business

FATHER 12. Name ADAMS, Clarence
13. Birthplace Pa.

MOTHER 14. Maiden name SMITH, Alice
15. Birthplace Md.

16. Informant wife: Mrs. Gladys Adams
Address Forestville, Md.

17. burial Date thereof 8-17-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Arlington National
Location Arlington, Va.

18. Funeral director W. Ernest Jarvis
Address 1432 U St., N.W., Wash., D.C.

19. 8-13 19 48
(Date rec'd by registrar) Registrar Mary C. Patterson

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 August 19 48 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 July 19 48 to 13 Aug. 19 48
and that I last saw him alive on 13 August 19 48

Immediate cause of death Dep. Med. Examiner Case DURATION 3.3 hrs.
Shock due to transfusion reaction

Due to

Due to

Other conditions Shot in left chest
May 23, 1948
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Unknown Date of 5/23/48
Where did injury occur? Forestville P.D. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Unk.

Means of injury Shot Injured at work?

Signature Frank J. Boschart M.D.
FRANK J. BOSCHART,
Dep. Med. Examiner M. D. or other

Address Gaithersburg, Md. Date signed 8-13-48

MARGIN RESERVED FOR BINDING

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VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

AUG 17 1948

BUREAU V. S.

PLEASE, WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 hours
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2000 E St., N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war WWI

3.(a) FULL NAME

ANDERSON, Albert

3.(b) Social Security Number

4. Sex male 5. Color or race Col. 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Gora L. Anderson
 7. Birth date of deceased (mo., day, yr.) March 5, 1896 6.(c) If alive, give age _____ years
 8. AGE: Years 52 Months 5 Days 20 It less than one day _____ hrs. _____ min.

9. Birthplace S.C.
 (Town, county, and state)
 10. Usual occupation Cook
 11. Industry or business Walter Reed Hospital
 12. Name ANDERSON, Perry dec.
 13. Birthplace S.C.
 14. Maiden name LINDSEY, Janie dec.
 15. Birthplace S.C.

16. Informant wife: Mrs. Cora L. Anderson
 Address 2000 E St., N.W., Wash., D.C.
 17. burial Date thereof 8-30-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Va.
 18. Funeral director Boyd Funeral Home S.P.
 Address 1238 20th St., N.W., Wash., D.C.
 19. 8-26 19 48
 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 August 19 48 at 7:50 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 August 19 48 to 25 August 19 48
 and that I last saw him alive on 25 August 19 48

Immediate cause of death Shock DURATION 24 hrs.

Due to Coma
 Due to Diabetes, Mellitus indef.
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury John W. Flynn Injured at work? _____
 23. SIGNATURE J. H. W. FLYNN, Lt. JG USN M. D. or other _____
 Address USNH Bethesda, Md. Date signed 8-26-48

RECEIVED
AUG 28 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08456

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months, 10 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 2 months, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 940 F St., S.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war WWI

3. (a) FULL NAME

ASHLEY, Frank

3. (b) Social Security Number

4. Sex male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Mrs. Ruby Ashley
 7. Birth date of deceased (mo., day, yr.) July 30, 1896 6. (c) If alive, give age _____ years
 8. AGE: Years 52 Months 0 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Macon, Ga.
 (Town, county, and state)
 10. Usual occupation unemployed
 11. Industry or business _____
 12. Name ASHLEY, Seaborn
 13. Birthplace Ga.
 14. Maiden name BOYKIN, Camilia
 15. Birthplace Ga.

16. Informant wife: Mrs. Ruby Ashley
 Address 940 F St., S.W., Wash., D.C.

17. burial Date thereof 8-30-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National
Arlington, Va.
 Location _____

18. Funeral director W. Ernest Jarvis
 Address 1432 U St., N.W., Wash. D.C.

19. 8-25- 1948 Mary C. Patterson
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 19 48 at 11:37A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 June 19 48 to 25 August 19 48
 and that I last saw him alive on 25 August 19 48

Immediate cause of death Pulmonary edema, acute

Due to Carcinoma, bronchogenic

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

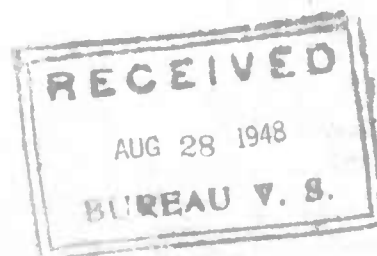
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury BC Kessler Injured at work? _____

23. SIGNATURE R. C. KESSLER, Lt. JG MC USN
 M. D. or other _____

Address USNH Bethesda, Md. Date signed 8-25-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 months, 2 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 11 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1927 East Hoffman Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ ✓

3.(a) FULL NAME

BARFIELD, Henry Gillen

3.(b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced separated
 6.(b) Name of husband or wife Mrs. Francis C. Barfield
 7. Birth date of deceased (mo., day, yr.) February 12, 1906 8.(c) If alive, give age _____ years
 8. AGE: Years 46 Months 5 Days 28 If less than one day _____ hrs. _____ min.

9. Birthplace N.C.
 (Town, county, and state)
 10. Usual occupation Riveter
 11. Industry or business _____
 12. Name BARFIELD, Morgan
 13. Birthplace S.C.
 14. Maiden name DOWNS, Missouri
 15. Birthplace S.C.

16. Informant wife: Mrs. Francis C. Barfield
 Address 59 Spencer Avenue, Chelsea, Mass.
 17. burial Date thereof 8-13-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Va.
 18. Funeral director W. W. CHAMBERS a. p.
 Address 1400 Chapin St., N.W., Wash., D.C.
 19. 8-10 1948 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

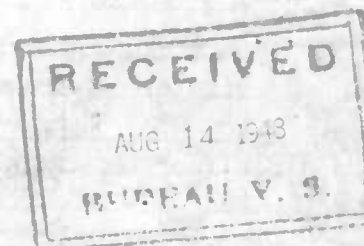
20. DATE OF DEATH 10 August 19 48 at 10:09 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 September 19 48 to 10 August 19 48
 and that I last saw him alive on 10 August 19 48

Immediate cause of death bronchopneumonia DURATION 2 days
 Due to Cirrhosis of liver indef.
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE H. R. Cooper M. D. or other _____
 Address USNH Bethesda, Md. Date signed 8-10-48



PLEASE WRITE PLAINLY, WITH UNFAINT INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:

County Montgomery
 City or town Browningsville (nr. Damascus)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? All his life.
 Hospital, institution, or street address where death occurred:
Died at home.
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Browningsville (nr. Damascus)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. —
 (If rural, give LOCATION)
 2.(a) If veteran, name war —

3. (a) FULL NAME

JAMES FILMORE BEALL

3. (b) Social Security Number

—

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife MARY FRANCES BEALL

7. Birth date of deceased (mo., day, yr.)

October 4, 18696. (c) If alive, give age 74 years

8. AGE:

Years

Months

Days

If less than one day

781011

hrs.

min.

9. Birthplace

Montgomery County, Maryland
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Own farm

MOTHER

FATHER

12. Name

Caleb Beall

13. Birthplace

Maryland

14. Maiden name

Lucinda Watkins

15. Birthplace

Maryland

16. Informant

Mrs. Filmore Beall

Address

Browningsville, Maryland.

17.

BurialDate thereof August 17, 1948
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Cemetery Bethesda

Location

Browningsville, Md.

18. Funeral director

J. B. Beall, Inc.

Address

Damascus, Maryland.

19.

Aug. 17 1948
(Date rec'd by registrar)Della M. Burdette
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 19 48 at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JANUARY 19 35 to August 15 19 48and that I last saw him alive on August 15 19 48

Immediate cause of death

Cerebral thrombosis
(Recurrent)

DURATION

6 days

Due to Generalized arterio-sclerosis
(cardio-vascular-renal disease
with nephro-sclerosis)

13 yrs. +

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

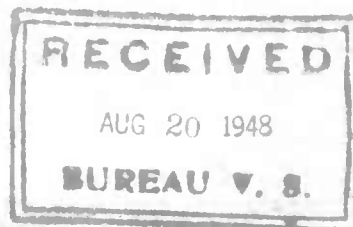
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. Kendrick Boyer
 M. D. or other
 Address Damascus, Maryland Date signed Aug. 16, 1948



RECEIVED

AUG 20 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:

County Montgomery
 City or town Colesville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Common Wealth Farm

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)Street No. 1807 Capitol View Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Beard Mitchell W. Beard

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife Ruby A. Beard

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 18578. AGE: Years Months Days If less than one day
91 4 25 hrs. min.9. Birthplace Hillsbora, W. Va.
 (Town, county, and state)10. Usual occupation Retired Farmer

11. Industry or business

12. Name Wallace Beard13. Birthplace W. Va.14. Maiden name Sarah Hinchman15. Birthplace W. Va.16. Informant Miss Grace BeardAddress 1807 Capitol View Ave.17. Burial Date thereof Aug. 19, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fort LincolnLocation Bladensburg, Prince George Co. Md.18. Funeral director Wanner E. Humphrey, Inc.Address 8434 Ga. Ave. Silver Spring, Md.19. Aug 21 19 48 Joseph M. Schaeff
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17/48 19 48 at 8:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1947 19 47 to 8/17/48 19 48and that I last saw him alive on 8/5/48 19 48

Immediate cause of death

Cardiac Failure

DURATION

1 yrDue to arteriosclerosis Diagnosed year

Due to

Other conditions Deafness

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Samuel Beard MD M. D. or otherAddress Kennington Md Date signed 8/17/48

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AUG 19 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 814

1. PLACE OF DEATH:
County Montgomery
City or town Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8504 Dixon Ave.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME
Eloss H. Beauchamp

3. (b) Social Security Number
579-10-0259

4. Sex male 5. Color or race Wh 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Catherine B.

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1894 6. (c) If alive, give age years

8. AGE: Years 53 Months 9 Days 14 If less than one day hrs. min.

9. Birthplace Crisfield, Md.
(Town, county, and state)

10. Usual occupation Salesman

11. Industry or business Insurance

12. Name John B. Beauchamp

13. Birthplace Delaware

14. Maiden name Edna Cox

15. Birthplace Md.

16. Informant Catherine B. Beauchamp

Address 1215 Holbrook Terrace, Wash. D.C.

17. Burial Date thereof Aug. 31, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Townsend,

Location Townsend, Delaware

18. Funeral director Warner E. Gumpshrey

Address Silver Spring, Md.

19. Aug 28 19 48 Joseph W. Chaffee
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 19 48 at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2nd 1948 to 1948 and that I last saw him alive on 1948

Immediate cause of death Thrombosis from R. & left wrists and elbow DURATION 1/2 hr.

Due to suicide

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 8-27-48

Where did injury occur? Silver Spring, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury finger nail file Injured at work? no

23. SIGNATURE Frank J. Brochant M.D. M. D. or other

Address Yairth... Date signed 8-28-48

MARGIN RESERVED FOR BINDING

VS A15 9-43-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

RECEIVED

AUG 31 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park, Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? at least 12 yrs

Hospital, institution, or street address where death occurred:

Washington Sanitarium & Hosp.How long in hospital or institution? 6 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 401 Greenwood Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Bertha E. Bell

3. (b) Social Security Number

4. Sex

Fe

5. Color or race

Caucasian married

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

David E. Bell

7. Birth date of deceased (mo., day, yr.)

Sept. 11, 18786. (c) If alive, give age 97 years

8. AGE:

Years

Months

Days

If less than one day

691120

hrs.

min.

9. Birthplace

Kearneysville, W. Va.
(Town, county, and state)

10. Usual occupation

Seamstress

11. Industry or business

FATHER

12. Name

Milton B. Miller

13. Birthplace

Shepherdstown, W. Va.

14. Maiden name

Edna Jane Trussell

15. Birthplace

Leetown, W. Va.

16. Informant

Patients clerk

17.

Burial Date thereof Sept. 2, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Rev. Washington Memorial Cemetery

Location

Riggs Road, Hyattsville, Md.

18. Funeral director

J. Arthur Swartz

Address

254 Carroll St. Takoma Park, Md. D. C.

19.

Sept 1 1948 J. Wm Dodd
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31, 1948 at 10:42 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 25, 1948 to Aug. 31, 1948and that I last saw him alive on Aug. 31, 1948

Immediate cause of death

DURATION

Generalized Carcinomatosis 15 mos.

Due to

Carcinoma of Clitoris 18 "

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Ca. of clitorisDate of op. 9-8-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Paul V. Starr, M.D.
M.D. or otherAddress Takoma Park, Md. Date signed 8-31-48

RECEIVED

SEP 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08462

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
 City or town Lake Park Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 weeks
 Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Silver Springs
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1509 Highland Drive
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Mrs Olive Ellen Bandle

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife John H. Bandle
 6. (c) If alive, give age 70 years
 7. Birth date of deceased (mo., day, yr.) September 22, 1886

8. AGE: Years 61 Months 10 Days 20 (hrs. min.)
 8. (c) If less than one day

9. Birthplace Austin Township Michigan
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name William Hart
 13. Birthplace Eastern Ontario Canada
 14. Maiden name Sarah Betty
 15. Birthplace Eastern Ontario Canada

16. Informant Mrs Charles Smith (Sister)
 Address 311 Trumbull St St Clair Mich

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 5, 1948
 (month) (day) (year)

Cemetery or crematory Holly Cemetery
 Location Holly, Oakland Co., Michigan

18. Funeral director Warner E. Humphrey Inc.
 Address 8434 Ga. Ave. Silver Spring, Md.

19. Aug 3 1948 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 1948 at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1948 to August 2 1948
 and that I last saw him alive on August 2 1948

Immediate cause of death Cerebral hemorrhage
corpus striatum, internal DURATION 2 wks

Due to Cause undetermined

Other conditions Cerebral hemorrhage system hypotension
Pulmonary disease (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Russell A. Quinn M.D.
Washington Sanitarium M. D. or other
 Address Washington Sanitarium Date signed Aug 2, 1948

RECEIVED

AUG 6 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County Montgomery
 City or town Gaithersburg Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 112 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montgomery
 City or town Gaithersburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Annice Vandenhoff Bonney -

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife John Bonney -
 6.(c) If alive, give age 1 years
 7. Birth date of deceased (mo., day, yr.) July 4 1860
 8. AGE: Years 88 Months 1 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Montgomery Md
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business _____
 12. Name Henry Vandenhoff -
 13. Birthplace N.Y.
 14. Maiden name Susan Hammer
 15. Birthplace Pa

16. Informant Matthew E. Horne Neese
 Address Gaithersburg Md
 17. Burial Date thereof 8/28/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Forest Oak Cemetery
 Location Gaithersburg Md
 18. Funeral director Essential & Funeral
 Address Gaithersburg Md
 19. Aug 27 1948 Abdus G. Corde
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Aug 25 1948 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-16 1947 to Aug-25-1948
 and that I last saw him alive on Aug-22-1948

Immediate cause of death

Senility
Myocardial Insufficiency
Due to
Myocardial Insufficiency
arterio-sclerotic

DURATION

5 years
(1)
(3)

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

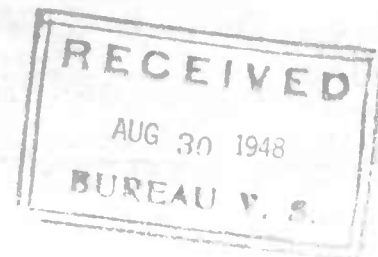
Means of injury _____

Injured at work? _____

23. SIGNATURE William E. Miller

M. D. or other _____

Address Gaithersburg Md Date signed 8/26/48



RECEIVED

AUG 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
 City or town Lakewood Park, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 27 days
 Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital
 How long in hospital or institution? 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick
 City or town Mr Airy
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Boyer Mr. Russell J

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married6. (b) Name of husband or wife Boyer Mrs. Edna Mae

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) August 7, 18818. AGE: Years Months Days If less than one day
67 0 1 hrs. min.9. Birthplace Clarksburg, Mont. Md.
(Town, county and state)10. Usual occupation Retired

11. Industry or business

12. Name J. Wesley Boyer13. Birthplace Montgomery County14. Maiden name Zarah Day15. Birthplace Montgomery County16. Informant Washington Sanitarium & Hosp. recd.Address Lakewood Park, Maryland17. Burial Date thereof Aug. 8, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Pine Grove CemeteryLocation Mt. Airy, Maryland18. Funeral director J. B. Beall, Inc.Address Damascus, Maryland19. Aug. 9 19 48
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1948 at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 13 19 48 to Aug. 8 19 48
and that I last saw him alive on August 8th 19 48

Immediate cause of death

Peritonitis, acute suppurative
due to cellulitis, pelvic
secondary to distended bladder
and infiltration due to prostatic
hypertrophy

DURATION

Other conditions Pulmonary (Pneumonia)congestion of lungs

(Include pregnancy within 3 months of death)

Major findings of operations Benign prostatic Hypert.Bladder diverticulum Date of op. _____Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Oliver E. Thompson M.D. M.D. or other11055 Old Bladyside Rd.
Address Silver Spring, Md. Date signed 8-8-48

RECEIVED

AUG 11 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County MontgomeryCity or town germantown - rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montg.City or town germantown

(If outside city or town limits, write RURAL and give nearest town)

Street No. rural

(If rural, give LOCATION)

2.(a) if veteran, name war

3. (a) FULL NAME

Isabelle Pulanney Brown

3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Carol A. Brown6. (c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) July - 11 - 18828. AGE: Years 66 Months 1 Days 1 If less than one day 0 hrs. 0 min.9. Birthplace Herndon, Va

(Town, county, and state)

10. Usual occupation house - keeping11. Industry or business at home12. Name Henry Palmer13. Birthplace Va.14. Maiden name Susan Howell15. Birthplace Va16. Informant Carol A. BrownAddress germantown, Md17. Burial Date thereof 8/16/48

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory Chestnut Grove CemeteryLocation Herndon, Va18. Funeral director Emuel C. GaitherAddress Gaithersburg, Md19. Aug 14 19 48 Abida G. Poole

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 12 - 19 48 at 9:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June - 8 - 19 48 to Aug - 12 - 19 48and that I last saw her alive on Aug - 12 - 19 48

Immediate cause of death

DURATION

Cancer of lungs

Due to

Cancer of left heart -

Due to

2 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE William C. Miller, M.D.

M. D. or other

Address Gaithersburg, Md Date signed 8/12/48

MARGIN RESERVED FOR BINDING

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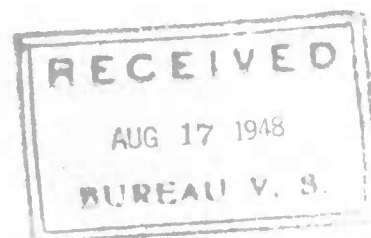
VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08465

501



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County... Montg Co
City or town... Gaithersburg Md,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... County...
City or town...
(If outside city or town limits, write RURAL and give nearest town)
Street No...
(If rural, give LOCATION)
2.(a) If veteran, name war...

3. (a) FULL NAME

Kate Lee Buck

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Thomas J. Buck

7. Birth date of deceased (mo., day, yr.) May 24th 1858 6. (c) If alive, give age... years

8. AGE: Years 90 Months 2 Days 17 If less than one day hrs. min.

9. Birthplace Linden Va.
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business John T. Walter

12. Name Va,

13. Birthplace

14. Maiden name Margaret A. Haines

15. Birthplace Va,

16. Informant Methodist Home, H Wilson

Address Gaithersburg Md,

17. Burial Date thereof 8/13th 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Forest Oak Cemetery

Location Gaithersburg Md,

18. Funeral director Ernest C. Gartner

Address Gaithersburg Md,

19. Aug 12 1948 Abner G. Cooke
(Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1948 at 8:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1942 to Aug-11-1948 and that I last saw him alive on Aug-10-1948

Immediate cause of death Smiley

Due to arterio-sclerosis

Due to mental deterioration

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William C. Miller M.D.

Address Gaithersburg Md Date signed 8/12/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 14 1948

BUREAU V. S.

08467

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 1/2 days
 Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital
 How long in hospital or institution? 3 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 9 Manor Circle
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3.(a) FULL NAME

Mrs. Rachel Louise Bullard

3.(b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widow
 6.(b) Name of husband or wife Robert L. Bullard
 7. Birth date of deceased (mo., day, yr.) Feb. 22, 1890 6.(c) If alive, give age..... years
 8. AGE: Years 69 Months 0 Days 6 If less than one day..... hrs. min.

9. Birthplace Quebec, Canada
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business.....
 12. Name Edmund L. Harvey
 13. Birthplace Canada
 14. Maiden name Helen Miner
 15. Birthplace Canada

16. Informant Washington Sanitarium & Hospital
 Address Takoma Park, Maryland
 17. Burial Date thereof Aug 25, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cedar Hill Cemetery
 Location Penn. Ave. & E. St. N. E. of Washington, D.C.
 18. Funeral director Arthur J. Hall
 Address 254 Carroll St., Takoma Park, D.C.
 19. 8/23 18 48
 (Date rec'd by registrar) Registrar William Nord

MEDICAL CERTIFICATION

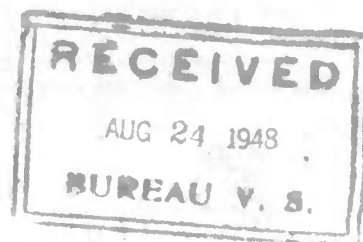
20. DATE OF DEATH August 22 19 48 at 4:25 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Aug. 17 19 48 to Aug. 22 19 48
 and that I last saw him/her alive on Aug. 22 19 48 at 2 P.M.
 Immediate cause of death Res. f. failure
+ heart failure
 DURATION.....
 Due to auricular fibrillation
 Due to Embolism to left thigh
with gangrene
 Other conditions Embolism to GI &
CNS. Diabetic mellitus
 (Include pregnancy within 3 months of death)
 Major findings of operations..... Date of op.
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....
 23. SIGNATURE J. A. Messin M.D.
 M. D. or other.....
 Address 28 Carroll Ave. Date signed 8/22/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:
County Montgomery Co
City or town Lerwood Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Montgomery
City or town Redland Rd
(If outside city or town limits, write RURAL and give nearest town)
Street No. Lerwood Md
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME Virginia West Byrd 3. (b) Social Security Number

4. Sex Female 5. Color or race C 6. (a) Single, married, widowed, or divorced widowed
6. (b) Name of husband or wife Wm Byrd
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 12, 1885
8. AGE: Years 62 Months 00 Days 00 If less than one day hrs. min.

9. Birthplace at home
10. Usual occupation

11. Industry or business

12. Name Felix West
13. Birthplace va
14. Maiden name Jane Fox
15. Birthplace va

16. Informant Wm Grant
Address Hyattsville Md

17. removal Date thereof Aug 16, 1948
(Burial, cremation, or removal. Which?) (Month) (day) (year)
Cemetery or crematory Hyattsville
Location Maryland

18. Funeral director F. Roachson
Address Hyattsville Md

19. Aug 16 19 48 Abraham G. Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH August 15 19 48 at 10:20 P.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 19 48 to August 15 19 48 and that I last saw him alive on August 9 19 48
Immediate cause of death Coronary Occlusion
Cardiorenal Disease
Hypertension
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wesley Sewell, M.D.
Address 100 Beech Rd Date signed Aug 16 19 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

211

1. PLACE OF DEATH:

County Montgomery
 City or town Claggettville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Claggettville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Emma J. Cain

3. (b) Social Security Number

m

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) Dec 19 - 1948
 8. AGE: Years 79 Months 8 Days 12 If less than one day
 hrs. min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Housewife

11. Industry or business

12. Name William Burdette
 13. Birthplace Damascus, Md
 14. Maiden name Ruth Watkins
 15. Birthplace Damascus, Md

16. Informant Mr John Mullins
 Address Bethesda Md

17. Burial (Burial, cremation, removal, Which?) Burial Date thereof Sept 2, 1948
 (month) (day) (year)

Cemetery or crematorium Montgomery
 Location Claggettville Md

18. Funeral director Rev W. Barker
 Address Claggettville Md

19. Aug 31 1948 Della K Burdette
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1948 at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept med exam to 19
 and that I last saw him alive on 19

Immediate cause of death Acute Cardiac Failure
 Due to Coronary Arteriosclerosis

Due to Coronary Arteriosclerosis
 Due to

Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Brionhart M.D.
Sept med exam M. D. or other
 Address Claggettville Md Date signed 8-31-48

08469

486



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age, is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159

08470

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 hours
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 16 Galveston Place, S.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

CARMAN, Maria

3. (b) Social Security Number

4. Sex female 5. Color or race W-US 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 23 August 1948
 8. AGE: Years _____ Months _____ Days _____ It less than one day 4 hrs. _____ min.

9. Birthplace Maryland Wash - Wash DC
 (Town, county, and state)
 10. Usual occupation _____
 11. Industry or business _____
 12. Name CARMAN, Wm. R.
 13. Birthplace Ky.
 14. Maiden name CULLEN, Marjorie
 15. Birthplace N.Y.

16. Informant fa: Mr. William R. Carman
 Address 16 Galveston Place, S.W., Wash., D.C.
 17. burial Date thereof 8-24-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Virginia
 18. Funeral director W. W. Chambers Onyx
 Address Georgetown, D.C.
 19. 8-23-48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

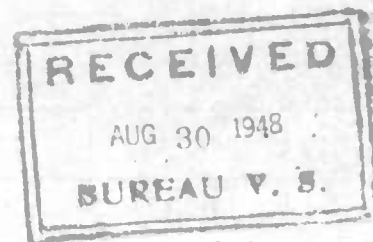
MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 19 48 at 12:40 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 August 19 48, to 23 August 19 48,
 and that I last saw her alive on 23 August 19 48.

Immediate cause of death Immaturity with multiple congenital deformities.
 Due to _____
 Due to Bilat. Hip dis & cleft palate
 Other conditions Bilat. polycystic kidney
Bilat. Clubfoot
 (Include pregnancy within 3 months of death)
 Major findings of operations _____
 Date of op. _____

Autopsy results confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE J. T. Fowler, Jr., Capt. MC USN
USNH Bethesda, Md.
 Address _____ Date signed 8-23-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 mon, 22 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 1 mon, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1645 13th St., N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war not a veteran

3. (a) FULL NAME

CLARK, George Calvin

3. (b) Social Security Number

4. Sex <u>male</u>	5. Color or race <u>Col.</u>	6. (a) Single, married, widowed, or divorced <u>widowed</u>	
6. (b) Name of husband or wife _____			
6. (c) If alive, give age _____ years			
7. Birth date of deceased (mo., day, yr.) <u>June 11, 1889</u>			
8. AGE: Years <u>59</u>	Months <u>2</u>	Days <u>22</u>	If less than one day _____ hrs. _____ min.
9. Birthplace <u>La.</u> (Town, county, and state)			
10. Usual occupation <u>carpenter</u>			
11. Industry or business _____			
FATHER	12. Name <u>CLARK, Calvin</u>		
	13. Birthplace <u>La.</u>		
MOTHER	14. Maiden name <u>WILBERT, Alice</u>		
	15. Birthplace <u>La.</u>		

16. Informant son: Sgt. Verden Clark, USMC
 Address 1645 13th St., N. W., Wash., D.C.

17. burial Date thereof _____
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Va.

18. Funeral director MELVIN & SCHEY F.S.W. Soc.
 Address 424 R St., N. W., Wash. D.C.

19. 8-23- 19 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 August 19 48 at 5:50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 July 19 48 to 23 Aug. 19 48
 and that I last saw him alive on 23 August 19 48

Immediate cause of death
Bronchopneumonia

Due to Intestinal Obstruction
(external causes)

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

DURATION
24 hrs.

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE R. N. Shelley
R. N. SHELLEY, Cdr. MC USN
 M. D. or other _____
 Address USNH Bethesda, Md. Date signed 8-23-48

08471

122b

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 25 1948

BUREAU V. S.

08472

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County Montgomery
 City or town Gaithersburg Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 1/2 - 8 mo
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montgomery
 City or town Gaithersburg Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Emma Sloven Corichoff

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced widow
 6. (b) Name of husband or wife Lewis a Corichoff
 7. Birth date of deceased (mo., day, yr.) May 5 1856

8. AGE: Years 1856 Months 92 Days 3 If less than one day 24 hrs. min.
 9. Birthplace Monterey Va
 (Town, county, and state)

10. Usual occupation House wife
 11. Industry or business _____

12. Name Thomas S. Sloven
 13. Birthplace Va

14. Maiden name Margaretta F. Lusher
 15. Birthplace Va

16. Informant Methodist Home (Nurses)
 Address Gaithersburg Md

17. Burial Date thereof 8/31/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Thornrose Cemetery
 Location Shanton Va

18. Funeral director Frank C. Garton
 Address Gaithersburg Md

19. Aug 30 1948 Alma Y. Cooke
 (Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 29 - 1948 at 6:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to Aug - 29 - 1948

and that I last saw him alive on Aug - 28 - 1948

Immediate cause of death Senility DURATION 6 yrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William D. Miller M.D. M. D. or other _____

Address Gaithersburg Md Date signed 8/30/48

MARGIN RESERVED FOR BINDING

VS A15 9.45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3

Hospital, institution, or street address where death occurred:

Washington Sanitarium & HospitalHow long in hospital or institution? 3

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 621 Carroll Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mr George Matthew Dawson

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male white widowed6.(b) Name of husband or wife Coseline Steelman7. Birth date of deceased (mo., day, yr.) August 16 1869

6.(c) If alive, give age. years

8. AGE: Years 78 Months 11 Days 19 If less than one day hrs. min.9. Birthplace Keystone, Penna.
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name Thomas Dawson13. Birthplace Crescloud14. Maiden name Rebecca Belcamp15. Birthplace Penna.

16. Informant

Address

17. Burial Date thereof Aug 27, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Sunset MemorialLocation Philadelphia, Pa. (Somerston, Pa.)18. Funeral director Arthur G. BlassAddress 351 Carroll St. Takoma Park, Md.19. Aug 5 1948 Registrar Wm. R. Bell

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1948 at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 3 1948 to Aug 4 1948and that I last saw him alive on Aug 4 1948

Immediate cause of death

Broncho-pneumoniaDue to ExhaustionDue to Carcinoma of Pancreas

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Concur above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Robert A. Hare M.D.Address Takoma Park, Md. Date signed 8/4/48

M.D. or other

RECEIVED

AUG 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age if especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 211

1. PLACE OF DEATH:

County Montgomery
 City or town Damascus, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Damascus
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Columbus W. Day

3. (b) Social Security Number

4. Sex

male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife Adelaide Hobbs Daydeceased 6. (c) If alive, give age _____ years7. Birth date of deceased (mo., day, yr.) Oct 31, 18558. AGE: Years 88 Months 9 Days 27 If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation farmer11. Industry or business farmer12. Name Jackson Day13. Birthplace and14. Maiden name Survilla Beall15. Birthplace Maryland16. Informant Vincent DayAddress Damascus, Maryland17. Burial Date thereof Aug. 30, 1988
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Methodist CemeteryLocation Damascus, Maryland18. Funeral director J. B. Beall, IncAddress Damascus, and19. Aug 30 19 88 Della A. Burdette
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 19 88 at P: M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 19 42 to August 28 19 88 and that I last saw him alive on August 28 19 88Immediate cause of death Bilateral bronchopneumonia DURATION 3 days
and arteriosclerotic cardiovascular disease 25 years

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James P. Kerr M.D. M. D. or otherAddress Damascus, Md. Date signed 8/30/88

RECEIVED

SEP 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

08475

223

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, institution, or street address where death occurred:
Washington Sanitarium Hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County Washington
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1464 Girard St., N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

de Martinez, Mrs. Rebecca Camarena

3. (b) Social Security Number

4. Sex Female 5. Color or race Caucas. 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife de Martinez, Mr. Rodolfo

7. Birth date of deceased (mo., day, yr.) June 26, 1924

8. AGE: Years 24 Months 2 Days 3 It less than one day hrs. min.

9. Birthplace Guadalajara, Jal., Mexico
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business Own Home

12. Name Mr. Leopoldo Camarena

13. Birthplace Guadalajara, Jal., Mexico

14. Maiden name Maria Romero

15. Birthplace Guadalajara, Jal., Mexico

16. Informant Hospital Records

Address Wash-Balto. Blvd., Dist. Line,

17. Removal Date thereof Aug 29-1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cremation Fort Lincoln August 30, 1948
 Cemetery or crematory

Location Wash-Balto. Blvd., Dist. Line,

18. Funeral director St. Peter's

Address 2901-14 St. N. Park, Md.

19. Aug 29 19 48
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29-1948 at 8:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-27-1948 to 8-29-1948

and that I last saw her alive on 8-27-1948

Immediate cause of death Pertussis

DURATION

Due to Pneumothorax of appendix

Due to

Other conditions Delivered on 8-25-48 by Dr. Paul Zamel. Premature separation of placenta at 7 mos. gestation

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Located at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emma Hughes

M. D. or other Takoma Park, Md.

Address Takoma Park, Md. Date signed 8-29-48

RECEIVED

AUG 31 1948

BUREAU, V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months, 28 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 2 months, 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1127 G St., N. E.
 (If rural, give LOCATION)
 2. (a) If veteran, name war WWI

3. (a) FULL NAME

DIGGS, Marion Howard

3. (b) Social Security Number

4. Sex <u>male</u>	5. Color or race <u>Col.</u>	6. (a) Single, married, widowed, or divorced <u>married</u>	
6. (b) Name of husband or wife <u>Christibell Diggs</u>			
6. (c) If alive, give age _____ years			
7. Birth date of deceased (mo., day, yr.) <u>December 7, 1894</u>			
8. AGE: Years <u>53</u>	Months <u>7</u>	Days <u>24</u>	If less than one day _____ hrs. _____ min.
9. Birthplace <u>Maryland</u> (Town, county, and state)			
10. Usual occupation <u>Custodian</u>			
11. Industry or business <u>Public School, Wash., D.C.</u>			
FATHER	12. Name <u>DIGGS, Ben.</u> <u>dec.</u>		
	13. Birthplace <u>Md.</u>		
	14. Maiden name <u>JACKSON, Louisa</u> <u>dec.</u>		
MOTHER	15. Birthplace <u>Md.</u>		

16. Informant Wife: Mrs. Christibell Diggs
 Address 1127 G St., N.E., Wash., D.C.
burial Date thereof 8-1-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Virginia
 18. Funeral director W. Ernest Jarvis
 Address 1432 U St., N. W., Wash., D.C.
Mary C. Patterson
Mary C. Patterson
 19. 8-1 19 48
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 August 19 48 at 8:10 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 May 19 48 to 1 August 19 48
 and that I last saw him alive on 1 August 19 48
 Immediate cause of death Broncho Pneumonia
 DURATION 72 hrs.
Hodgkins Disease
 Due to 9 mons.
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results Confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE A. E. MARLAND, Jr. It. JC MS USN
M. D. or other
 Address USNH Bethesda, Md. Date signed 8-1-48

RECEIVED

AUG 5 1948

BUREAU V. S.

08477

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Dead on arrival
Hospital, institution, or street address where death occurred: Suburban Hosp.
8600 Old Georgetown Hospital
How long in hospital or institution? Dead on Arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Montrose
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. #5 - Randolph Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war NONE

3.(a) FULL NAME

Edison
Robert Dodson

3.(b) Social Security Number

NONE

4. Sex M 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife NONE

6.(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1937

8. AGE: Years 10 Months 10 Days 3 It less than one day - hrs. - min.

9. Birthplace At Trivillan md.
(Town, county, and state)

10. Usual occupation school child

11. Industry or business Public School

12. Name Burgess E. Dodson

13. Birthplace Virginia

14. Maiden name Dollie Hildebrandt

15. Birthplace Fredrick Co., Maryland

16. Informant Burgess E. Dodson - Father

Address Randolph Rd., R.F.D. #5, Rockville

17. Burial Date thereof August 11, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Monocacy Cemetery

Location Beallsville, Maryland

18. Funeral director Wm. James Humphrey

Address Bethesda, Maryland

19. 8/9 48 Wm. E. Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9th 1948, at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep med exam 1948 and that I last saw him alive on 1948

Immediate cause of death Bullet wound penetrating and

Due to skull. At cranial base

Due to region

Due to accidental

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8-9-48

Where did injury occur? Rockville, R.F.D. #5 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury gun shot Injured at work? no

23. SIGNATURE Frank J. Bernhart M.D.

Address Quincy, Md. Date signed 8-9-48

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. Indicate exact age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 14 1948

BUREAU V. S.

08470

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 246

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since July 30, 48

Hospital, institution, or street address where death occurred:

Suburban Hospital - 8600 Old Georgetown Rd.How long in hospital or institution? Since July 30, 48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery Co.City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. 4801 Montgomery Lane
(If rural, give LOCATION)2(a) If veteran, name war None

3. (a) FULL NAME

Allyn G. Doyle

3. (b) Social Security Number

*None listed

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

None

7. Birth date of

deceased (mo., day, yr.)

Nov. 1, 1923

6. (c) If alive, give age

- years

8. AGE:

Years

Months

Days

If less than one day

2481

hrs.

min.

9. Birthplace

Washington D.C.
(Town, county, and state)

10. Usual occupation

Clark Typist

11. Industry or business

Hospital

MOTHER FATHER

12. Name

C. Eugene Doyle

13. Birthplace

Washington D.C.

14. Maiden name

Ruth Cartwright

15. Birthplace

Washington D.C.

16. Informant

Father - C. Eugene Doyle

Address

Bethesda, Md.

17.

Storage
(Burial, cremation, or removal. Which?)Date thereon August 1, 1948
(month) (day) (year)

Cemetery or crematory

Rock Creek Cemetery

Location

Washington, D. C.

18. Funeral director

Wm. R. Ransom, Pumphrey

Address

Bethesda 14, Maryland

19.

8/3 48
(Date rec'd by registrar)Wm. Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 19 48, at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med. Exam Caseand that I last saw him alive on 19

Immediate cause of death

Phos. Carbide poisoning
(Suicide)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 8.2.48

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

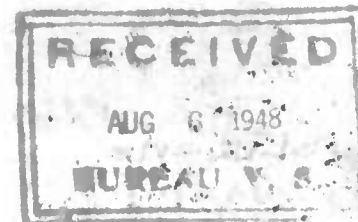
23. SIGNATURE

Frank J. Broschart M. D.
Dep med. Exam M. D. or other
Frank J. Broschart M. D. Date signed 8.2.48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 211

08479

93d

1. PLACE OF DEATH:

County Montgomery
 City or town Claggetttsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 27 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Claggetttsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.D. Mt. Airy
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

LAURA C. Easton

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Lewis B. Easton
deceased 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Sept. 19, 1871
 8. AGE: Years 76 Months 11 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Fredricks Co. Md.
 (Town, county, and state)

10. Usual occupation NONE

11. Industry or business

12. Name Thomas E. Moxley
Md.

13. Birthplace

14. Maiden name Annie M. Riley
Md.

15. Birthplace

16. Informant Mrs. John E. Sworthy
Mt. Airy, Md.
 Address

17. Burial Date thereof 8-28-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Montgomery Chapel

Location Claggetttsville, Montg. Co. Md.

18. Funeral director G. M. Waltz

Address Winfield, Md.

19. August 27, 48 Della C. Burdett
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 19 48 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 19 48 to August 29 19 48
 and that I last saw her alive on August 23 19 48

Immediate cause of death Cerebral monkey right DURATION 3 days

Due to atherosclerotic cardiovascular disease 10 years

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations. Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James P. Kerr M.D. M. D. or other
Damascus, Md. Date signed 8/27/48

RECEIVED

AUG. 30 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va. County _____
 City or town Arlington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1556 N. Bryan St.
 (If rural, give LOCATION)
 2. (a) ☒ veteran, name war Sp. Am. War

3. (a) FULL NAME

Evans, Elmer Ellsworth

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Mrs. Irene S. Evans
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) November 30, 1882
 8. AGE: Years 65 Months 8 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Ill.
 (Town, county, and state)
 10. Usual occupation AUDITOR
 11. Industry or business _____
 12. Name EVANS, James dec. _____
 13. Birthplace Tenn.
 14. Maiden name SENTINY, Minnie dec. _____
 15. Birthplace Ohio

16. Informant wife: Mrs. Irene S. Evans
 Address 1556 N. Bryan St., Arlington, Va.
 17. burial Date thereof 9-1-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Virginia
 18. Funeral director W.W. CHAMBERS M.K. Wade
 Address 3072 M ST. N.W. Washington D.C.
 19. 8-27 19 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 19 48 at 11:15 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 August 19 48 to 27 August 19 48
 and that I last saw him alive on 27 August 19 48
 Immediate cause of death Shock DURATION 2 hrs.
 Due to Diabetes Mellitus yes?
 Due to Atrophy of Pancreas yes?
 Other conditions Cholelithiasis yes?
 (Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury D E Billman Injured at work? _____
D. E. BILLMAN, Lt. JG MC USN
 23. SIGNATURE _____ M. D. or other _____
 Address USNH Bethesda, Md. Date signed 8-27-48

08480

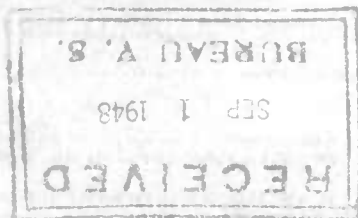
61

MARGIN RESERVED FOR BINDING

VS A15

9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 223-

1. PLACE OF DEATH:

County Montgomery
 City or town Farmers Park Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month, 7 days, 5 hours
 Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital
 How long in hospital or institution? 1 month, 7 days, 5 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County Arlington
 City or town Arlington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1512 Arlington Ridge Rd.
 (If rural, give LOCATION) Arlington, Va.
 2. (a) If veteran, name war

3. (a) FULL NAME

Mr Elmon E. Ewing

3. (b) Social Security Number

4. Sex male 5. Color or race cauc. 6. (a) Single, married, widowed, or divorced widower
 6. (b) Name of husband or wife Rda. G. Haislop Ewing
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Feb. 16, 1876
 8. AGE: Years 72 Months 6 Days 25 If less than one day ? hr. ? min.

9. Birthplace Washington D.C.
 (Town, county, and state)
 10. Usual occupation Mechanical Contractor
 11. Industry or business Standard Eng. Co., Inc.
 12. Name William G. Ewing
 13. Birthplace Maryland
 14. Maiden name Ellice A. Wright
 15. Birthplace Baltimore, Md.

16. Informant Hospital Records
 Address Washington San. & Hospital
1200 Park Rd. N.W.
Bureau
 17. Date thereof Aug 31-1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory GLENWOOD

Location WASHINGTON DC
 18. Funeral director Jos. Samuels Sons
 Address 1766 Pa. Ave. N.W.-D.C.
Aug 28 19 48 J.W. Dwyer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27-48 19..... at 7:00 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from last 4-5 yrs 19..... to 19.....
 and that I last saw him live on 8-27 19.....
 Immediate cause of death terminal heart disease DURATION
atherosclerosis; general
arteriosclerosis; cerebral hemorrhage (left side)
coronary artery disease
hypertension; chronic 2 wk
6-8 yrs
 Other conditions
 (Include pregnancy within 3 months of death)
 Major findings of operations 0 Date of op. 8

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 0
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE Chas. H. Sholomon, M.D.
 Address 500 Indiana St. N.W. Date signed 8/27/48

RECEIVED

AUG 31 1943

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

08482

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

108 Woodmoor Drive.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 108 Woodmoor Drive
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Milina Mary Figallo

3. (b) Social Security Number

4. Sex Female 5. Color or race Wh. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Paul J. Figallo

7. Birth date of deceased (mo., day, yr.) August 14, 1907
6. (c) If alive, give age _____ years

8. AGE: Years 41 Months 0 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation Owner & Operator Beauty Shop

11. Industry or business

12. Name Ralph Detufo

13. Birthplace Italy

14. Maiden name Anne Perone

15. Birthplace Italy

16. Informant Paul J. Figallo

Address Silver Spring, Md.

17. Burial Date thereof August 30, 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Marys

Location Washington, D.C.

18. Funeral director Warner E. Humphreys, Inc.

Address Silver Spring, Md.

19. Aug 27 19 48 Josephine Schaeffe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 19 48 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dr. med. Exam case to 19
and that I last saw him alive on 19

Immediate cause of death

DURATION

Coronary occlusion

7 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

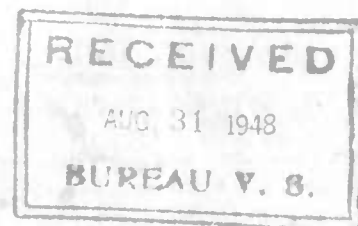
Frank J. Baruch M.D.
Dr. med. Exam M.D. or other
Yarick, Md. Date signed 8-26-48

MARGIN RESERVED FOR BINDING

VS-AJ5 9-45-15M

VS-AJ5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months, 22 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 3 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 325 Elm St., N. W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war WWII

3. (a) FULL NAME

FLETCHER, Chester

3. (b) Social Security Number

4. Sex male 5. Color or race Col. US 6. (a) Single, married, widowed, or divorced separated
 6. (b) Name of husband or wife Mrs. Covie Fletcher
 7. Birth date of deceased (mo., day, yr.) August 10, 1899
 6. (c) If alive, give age _____ years
 8. AGE: Years 49 Months 0 Days 2 If less than one day _____ hrs. _____ min.

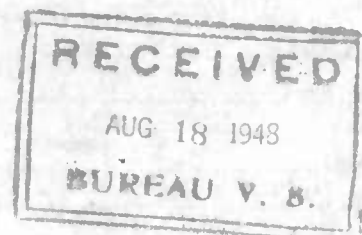
9. Birthplace Virginia
 (Town, county, and state)
 10. Usual occupation Bar Tender
 11. Industry or business _____
 12. Name FLETCHER, John dec.
 13. Birthplace Va.
 14. Maiden name WASHINGTON, Annie dec.
 15. Birthplace Va.

16. Informant sister: Mrs. Lucy Mathews
 Address 325 Elm St., N.W., Wash., D.C.
 17. burial Date thereof 8-16-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Virginia
 18. Funeral director BOYD Funeral Home
 Address 1238 20th St., N. W., Wash., D.C.
Mary C. Patterson
8-13 48 Mary C. Patterson
 19. (Date rec'd by registrar) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 August 1948 at 8:40 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 April 1948 to 12 August 1948
 and that I last saw him alive on 12 August 1948
 Immediate cause of death Edema, Lung DURATION 48 hrs.
 Due to Carcinoma, stomach indef.
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE A. E. MARLAND, LTJG MC USN
 M. D. or other _____
 Address USNH Bethesda, Md. Date signed 8-13-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 26 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.How long in hospital or institution? 1 month, 26 days

3. (a) FULL NAME

Mark Conrad GIMPEL

3. (b) Social Security Number

4. Sex

male

5. Color or race

W-US

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 13, 1948

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

424

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
MOTHER

12. Name

GIMPEL, Herbert

13. Birthplace

Ohio

14. Maiden name

ROSENBERG, Ruth E.

15. Birthplace

Montana

16. Informant

father: Lt. Herbert Gimpel, USN

Address

8605 Hempstead Ave., Bethesda, Md.

17.

burial

Date thereof

8-9-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Arlington National

Location

Arlington, Va.

18. Funeral director

W.W. CHAMBERS CO.

Address

3072 M St., NW, Washington, D.C.

19.

8-71848Mary S. Patterson

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MontgomeryCity or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8605 Hempstead Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 August 19 48 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11 June19 48, to7 August 1948and that I last saw him alive on 7 August 1948

Immediate cause of death

Bronchopneumonia

DURATION

2 hours

Due to

Amyotonia Congenita

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Andrew M. MargilethA. M. MARGILETH, Lt. JG. MC. USN

M. D. or other

Address USNH Bethesda, Md. Date signed 8-7-48

RECEIVED

AUG 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08485

Reg. Dist. No. 218

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(City or town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Aug 30

19 48 Abner D. Cook

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

19 48 at 4 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

June 21 19 48 to Aug 27 19 48

and that I last saw him alive on Aug 27 19 48

Immediate cause of death

cardio-renal
myocardial degeneration
chronic dilatative
hypertension
high arterial tension

DURATION

3 months

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

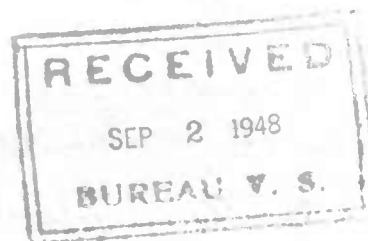
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 8/28/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ITEM of age Evidence for change/shown on: MARYLAND STATE DEPARTMENT OF HEALTH X
2411 N. Charles St., Baltimore 46d

08486

PLM No. G 117 SEP 30 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery
City or town... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 19 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 3 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... D.C. County...
City or town... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1333 11th St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war... WWI

3. (a) FULL NAME

GREGG, Nimrod

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) December 28, 1890 6. (c) If alive, give age..... years

8. AGE: Years 57 Months 7 Days 28 If less than one day..... hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Civil Service

11. Industry or business Veterans Administration

12. Name GREGG, Jehu dec

13. Birthplace Pa.

14. Maiden name BROADWATER, Martha Ann dec

15. Birthplace Pa.

16. Informant sister: Mrs. Rachael Michael

Address 307 Johnson St., Western Port, Md.

17. burial Date thereof 8-31-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director W. W. Chambers ETC.

Address Georgetown, D.C.

19. 8-27 19 48 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 August 19 48 at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 May 19 48 to 26 August 19 48 and that I last saw him alive on 26 August 19 48

Immediate cause of death..... DURATION

Adenocarcinoma of rectum & extensive metastases

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Antopsy results confirms above Date of op.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

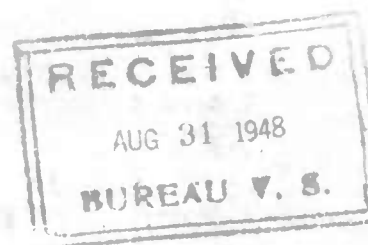
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury injured at work?

23. SIGNATURE R. C. KESSLER, Lt JG MC USN

Address USNH Bethesda, Md. Date signed 8-27-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08487 132 714

1. PLACE OF DEATH:

County MONT GOMERYCity or town SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 MONTHS

Hospital, institution, or street address where death occurred:

1954 CAPITAL VIEW AVE., SILVER SPRING

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State IOWA County MAHASKACity or town OSKALOOSA
(If outside city or town limits, write RURAL and give nearest town)Street No. 419 N. FIRST ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

WILHELM GRONEWALD

3. (b) Social Security Number

NONE

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife

BELLE DINA GOURLEY

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

FEBRUARY 2, 1865

8. AGE:

Years

Months

Days

If less than one day

8361

hrs.

40 min.

9. Birthplace

GERMANY

(Town, county, and state)

10. Usual occupation

FARMER

11. Industry or business

PREVIOUSLY SELF-EMPLOYED

FATHER

12. Name

GERHARD GRONEWALD

MOTHER

13. Birthplace

GERMANY

14. Maiden name

DINA (NOT KNOWN)

15. Birthplace

GERMANY

16. Informant

ROBERT G. GRONEWALD (Son)

Address

1954 CAPITAL VIEW AVE., SILVER SPRING

17.

Removal & Burial

Date thereof

Aug. 4, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Kirkville Cemetery

Location

Kirkville, Wapello Co. Iowa.

18. Funeral director

Warrin E. Humphrey, Inc.

Address

8434 Ga. Ave. Silver Spring, Md.

19.

Aug 4

1948

(Date rec'd by registrar)

Joseph M. Schaeff

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1948 at 12:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JUNE 3 1948 to AUGUST 4 1948and that I last saw him alive on AUGUST 4 1948

Immediate cause of death

INANITION

DURATION

2 MONTHS

Due to

TUBERCULOUS LARYNGITIS1 MONTH

Due to

PULMONARY TUBERCULOSIS, REINFECTION4 MONTHS

Other conditions

TUBERCULOUS CYSTITIS2 MONTHSTRIGEMINAL NEURALGIA12 YEARS

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

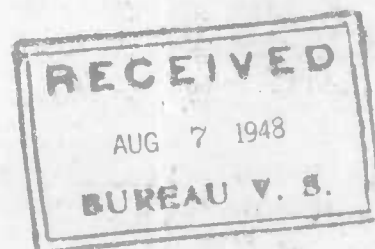
23. SIGNATURE

Robert G. Angley M.D.

M. D. or other

Address

106 Del Ray AveDate signed Aug 4, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

10,424 Old Bladensburg Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 10,424 Old Bladensburg Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

CHARLES C. HALL

3. (b) Social Security Number

578-07-4715A

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male

white

married

6.(b) Name of husband or wife Bertie A. Hall

6.(c) If alive, give age years

T. Birth date of

deceased (mo., day, yr.)

March 26, 1883

8. AGE:

Years

Months

Days

If less than one day

65

4

14

hrs.

min.

9. Birthplace Tazewell, Va.

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER

12. Name William R. Hall

13. Birthplace Tazewell, Va.

14. Maiden name Mattie Bowling

15. Birthplace Virginia

16. Informant Mrs. Bertie A. Hall

Address 10,424 Old Bladensburg Rd., S. S.

17. Burial Date thereof Aug. 12, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Colesville Cemetery

Location Colesville, Md.

18. Funeral director Warner E. Pumphrey, Inc.

Address 8434 Ga. Ave., Silver Spring, Md.

19. Aug 10 19 48 Joseph W. Schaeff
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 19 48 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death

Coronary Thrombosis

DURATION

1 M. or.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

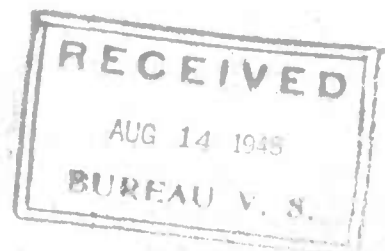
Wendell D. Cross M.D.
Silver Spring, Md. Date signed 8/10/48

M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08483

Reg. Dist. No. 316

1. PLACE OF DEATH:

County Montgomery Co.City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 22 yrs 9 mos, 28 days

Hospital, institution, or street address where death occurred:

Suburban Hospital 8600 Georgetown Rd. Bethesda, Md.How long in hospital or institution? 5 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Cabin John: Bethesda, Ind.
(If outside city or town limits, write RURAL and give nearest town)Street No. 6th Street
(If rural, give LOCATION)2.(a) If veteran, name war World War II.

3. (a) FULL NAME

Norman Cyrus Hunt Jr

3. (b) Social Security Number

215-20-3163

4. Sex

M

5. Color or race

W.

6.(a) Single, married, widowed or divorced

Single6.(b) Name of husband or wife None

7. Birth date of

deceased (mo., day, yr.)

October 26, 1925

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

229281 hrs.- min.

9. Birthplace

Washington, D.C.
(Town, county, and state)

10. Usual occupation

meat cutter

11. Industry or business

Safeway Stores, Inc.

12. Name

Norman C. Hunt, Sr.

13. Birthplace

East Stroudsburg, Penn.

14. Maiden name

Sarah J. Stacks

15. Birthplace

Montgomery Co., Md.

16. Informant

Norman C. Hunt, Sr.

Address

6th Street Cabin John, Md.

17.

BurialDate thereof August 31, 1948

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Arlington National Cemetery

Location

Arlington, Virginia

18. Funeral director

Wm. Paulsen Humphrey

Address

Bethesda, Maryland

19.

8/29/48

(Date rec'd by registrar)

Wm E Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 2719 48, at 1:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med exam caseand that I last saw him alive on 19

Immediate cause of death

DURATION

Fracture of skull1 hr

Due to

auto accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

accidentDate of 8-27-48

Where did injury occur?

Rockville

(City or town)

(County)

(State) Montg. Md

Injured at home, farm, industry, publc place (where?)

Highway

Means of injury

auto accident

Injured at work?

no

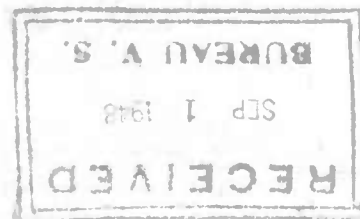
23. SIGNATURE

Frank J. Broschart M.D.

M. D. or other

Address

Gaithersburg MdDate signed 8-27-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery
City or town Clarksburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Montg & Gen Hosp Inc
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Montgomery Heights Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Bertie O. Hurley

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Claude C Hurley

7. Birth date of deceased (mo., day (yr.)) July 24 - 1888 6.(c) If alive, give age _____ years

8. AGE: Years 60 Months 0 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business Home

12. Name Edward L. Belliron

13. Birthplace Maryland

14. Maiden name Hattie V. Mosley

15. Birthplace Maryland

16. Informant Mr Claude C Hurley

Address Monrovia Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Aug 10 - 1948
(month) (day) (year)

Cemetery or crematory Montgomery Church

Location Near Clarksburg Md

18. Funeral director Roy W. Barker

Address Clarksburg Md.

19. Aug 10 1948 Gertrude B Fowler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Aug 8 1948 at 2nd a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1948 to Aug 8 1948

and that I last saw h. or alive on Aug 7 1948

Immediate cause of death Uremia

DURATION 6 days

Due to Hypertension - Cardiac. Undeter.

Vascular Dementia

Due to _____

Other conditions Atherosclerosis, Undeter.

marked
(Include pregnancy within 3 months of death)

Major findings of operations. _____ Date of op. _____

Autopsy results. _____
PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Jack Summacker M.D.
Address Clarksburg Md M. D. or other _____

Date signed 9 Aug 48

MARGIN RESERVED FOR BINDING

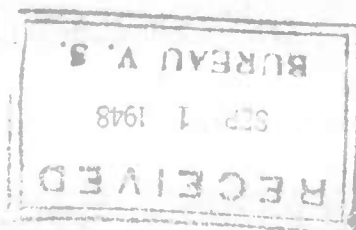
VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 16 1948

BUREAU V. S.



RECEIVED

AUG 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery
City or town Brookville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs
Hospital, institution, or street address where death occurred:
Montgomery Co San Hosp
How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Brookville
(If outside city or town limits, write RURAL and give nearest town)
Street No. None
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME

Sallie R Jamney

3. (b) Social Security Number

None

4. Sex F 5. Color or race N 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife John H. Jamney
6. (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Dec 16 1869

8. AGE: Years 79 Months 7 Days 8 If less than one day hrs. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation H-H

11. Industry or business —

12. Name Ethel M. Jamney

13. Birthplace VA

14. Maiden name Mary Randolph

15. Birthplace VA

16. Informant Richard Jamney

Address Ashton, Maryland

17. Burial Date thereof August 27, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Woodside Cemetery, Md.

Location Brinklow, Maryland

18. Funeral director Wm. Paulson Humphrey

Address Bethesda 14, Maryland

19. Aug 26 1948 Fertide B Towler
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26 1948 at 6 a 07 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/7/ 1948 to 8/26/ 1948 and that I last saw him alive on 8/26/ 1948

Immediate cause of death Arteriosclerosis DURATION 5

Due to General Arteriosclerosis & nephritis

Due to Fracture of RT Hip 28 days

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8/12/48

Where did injury occur? Brookville (City or town) Montgomery (County) MD (State)

Injured at home, farm, industry, public place (where?) Country Lodge

Means of injury Fall Injured at work? —

23. SIGNATURE Sandy Sp M. D. or other —

Address — Date signed 8/26/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Rockville Pike, Rockville, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11/18/47

Hospital, institution, or street address where death occurred:

Waverly SanitariumHow long in hospital or institution? 11/18/47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MontgomeryCity or town Cherry Chase
(If outside city or town limits, write RURAL and give nearest town)Street No. 8 Linnet St.
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Emma Charlotte Johnson

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Col. Elza Johnson6. (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.)

1/10/1881

8. AGE:

67 Years

Months

7

Days

18

If less than one day

- hrs. - min.

9. Birthplace

Breda, Sweden
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

Housewife

MOTHER FATHER

12. Name

James M. Johnson

13. Birthplace

Sweden

14. Maiden name

Marie Kristina Carlsson

15. Birthplace

Sweden

16. Informant

Mrs. Rita Rodda

Address

Fulls Church, Va. Phone 4456

17. Burial

(Burial, cremation, or removal. Which?)

BurialDate thereof August 24, 1948
(month) (day) (year)

Cemetery or crematory

Arlington National

Location

Arlington, Virginia

18. Funeral director

Wm. R. Humphrey

Address

Bethesda, Md.

19.

(Date rec'd by registrar)

8/25/48Wm E Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 1948, at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 18, 1947, to Aug. 21, 1948and that I last saw her alive on August 20th, 1948

Immediate cause of death

Bronchopneumonia

DURATION

3 days

Due to

chronic myocarditis

Due to

arteriosclerosis

Other conditions

arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. E. Jones

Address

Bethesda, Md. Date signed Aug 23/48

RECEIVED

AUG 28 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery
 City or town... Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 hour
 Hospital, institution, or street address where death occurred:
Suburban Hospital
 How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery
 City or town... Westmoore (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... none
 (If rural, give LOCATION)
 2.(a) If veteran, name war... No

3. (a) FULL NAME

WALTER JEFFERSON JOHNSON

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 8.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Rose A. Johnson
 7. Birth date of deceased (mo., day, yr.) May 20, 1861 8.(c) If alive, give age dec. 9 years
 8. AGE: Years 87 Months 87 Days 3 It less than one day 8 hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Aug 19 48 at 11 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 47 to 28 Aug 19 48
 and that I last saw him alive on 27 Aug 19 48
 Immediate cause of death Coronary heart failure

DURATION

6 mosDue to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Physician's results General Arteriosclerosis, enlarged heart
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W S Murphy MD M. D. or otherAddress Rockville Md Date signed 30 Aug 48

9. Birthplace St. Marys County, Maryland
 (Town, county, and state)
 10. Usual occupation Retired - Watchman
 11. Industry or business
 12. Name Unknown
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant Mrs. Frederick Wilkerson-daughter
 Address Westmoore, Maryland

17. Burial Date thereof August 31, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Marys Catholic Cemetery
 Location Rockville, Maryland

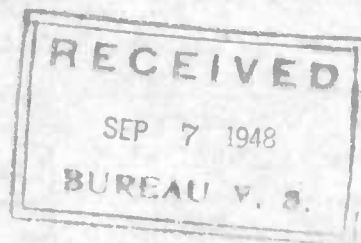
18. Funeral director W S Murphy
 Address Bethesda, Maryland

19. 8/31 19 48 W S Murphy
 (Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
401- West Montg. Ave.
How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 401- West Montg Ave
(If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME

Thos Laurence Jones

3. (b) Social Security Number

none

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Charles B. Jones

7. Birth date of deceased (mo., day, yr.) July 2 - 1854 6.(c) If alive, give age 94 years

8. AGE: Years 94 Months 1 Days 7 If less than one day hrs. min.

9. Birthplace Rockville - Montg. Co - Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Domestic helper

12. Name James Edmund Lyddane

13. Birthplace Montg. Co - Maryland

14. Maiden name Harriet H. Magruder

15. Birthplace Montg. Co - Maryland

16. Informant Mrs. Chas. Brand - Sr.

Address 115 - Forest Ave - Rockville - Md.

17. Burial Burial Date thereat Aug 12 1948
(Burial, cremation, or reinterment. Which?) (month) (day) (year)

Cemetery or crematory Rockville Union

Location Dr. Rockville - Montg. Co - Maryland

18. Funeral director Wm. Reubert Jones

Address Rockville - Maryland

19. 8/10 19 48
(Date rec'd by registrar) Registrar W. H. Hays

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 19 48 at 1:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/3 19 46 to 8/9 19 48 and that I last saw him alive on 8/9 19 48

Immediate cause of death arteriosclerosis

Due to arteriosclerosis

Due to arteriosclerosis

Other conditions Cerebral Hemorrhage

(Include pregnancy within 3 months of death)

Major findings of operations 4 hours

Antemortem results Physician: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work?

23. SIGNATURE C. E. Hawks M.D. M. D. or other 8/10/48

Address Rockville Md Date signed 8/10/48

08496

946

213

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 13 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month, 19 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 1 month, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County
 City or town Arlington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4411 Lee Highway
 (If rural, give LOCATION)
 2. (a) If veteran, name war ✓

3. (a) FULL NAME

KARLSTROMER, Carl Berger

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced divorced
 6. (b) Name of husband or wife
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) March 14, 1889
 8. AGE: Years 59 Months 5 Days 27 If less than one day hrs. min.

9. Birthplace Sweden
 (Town, county, and state)
 10. Usual occupation unemployed
 11. Industry or business
 12. Name KARLSTROMER, Emil
 13. Birthplace Sweden
 14. Maiden name YOUNGSTROMER, Yelva
 15. Birthplace Sweden

16. Informant son: Pvt. Robert C. Karlstromer
Squad BX2, Flight 3396
 Address Sheppard Air Force Base, Wichita Falls, Texas

17. cremation Date thereof 9-2-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory
 Location Sweden

18. Funeral director Ives Funeral Home R & C
 Address Arlington, Va.

19. 9-1-48 19-48 Mary C. Patterson Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 August 19 48 at 8:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 July 19 48 to 31 August 19 48
 and that I last saw him alive on 31 August 19 48

Immediate cause of death Congestive Heart Failure DURATION 1 1/2 mons.

Due to Calcific aortic stenosis indef.

Due to Mitral valvulitis indef.

Other conditions Arteriosclerosis, Generalized indef.

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Keith D. Powelson
KEITH D. POWELSON, Lt JG MC USN
 M. D. or other

Address USNH Bethesda, Md. Date signed 9-1-48

RECEIVED

SEP 7 1943

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH: Montgomery
 County Prince George
 City or town Wheaton (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 Months
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: Montgomery
 (For newborn infants give residence of mother)
 State Maryland County Prince George
 City or town Wheaton (If outside city or town limits, write RURAL and give nearest town)
 Street No. 11712 GRANDVIEW (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

ADDABELLE

KNAPP

3. (b) Social Security Number

4. Sex FEMALE 5. Color or race White 6.(a) Single, married, widowed or divorced Widowed
 6.(b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) August 31, 1886 8.(c) If alive, give age 61 years
 8. AGE: Years 61 Months 11 Days 1 If less than one day hrs. min.

9. Birthplace CANISTEO, NEW YORK (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business
 FATHER 12. Name AUSTIN HUFF
 13. Birthplace NEW YORK
 MOTHER 14. Maiden name SENA FARRELL
 15. Birthplace NEW YORK

16. Informant GERTRUDE BEACH
 Address 11712 GRANDVIEW, WHEATON, MD.
 17. Burial Date thereof Aug 3, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Washington National Park
 Location Suitland
 18. Funeral director W. W. Chambers Co.
 Address 1400 Chapin St. N.W.
 19. Aug 1 19 48 Josephine M. Schaeffer
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 19 48 at 2:45 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 21, 1948 to 2:15 P. 19 48
 and that I last saw him alive on 2:15 PM 8/1/48
 Immediate cause of death Carcinoma sigmoid DURATION 6 mos
 Due to
 Due to
 Other conditions none
 (Include pregnancy within 3 months of death)
 Major findings of operations Inoperable carcinoma recto sigmoid colon Date of op. 1/25, 1948
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Joseph H. Cowan M.D. M. D. or other
 Address 2922 Newark St NW Date signed 8/1/48

RECEIVED

AUG 5 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:

County Montgomery
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? twenty-five years
 Hospital, institution, or street address where death occurred:
2309 Michigan Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MARYLAND County MONTGOMERY
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2309 Michigan Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

MOSE LAIR

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widower, or divorced

MALE COLORED WIDOWER

6. (b) Name of husband or wife FANNIE LAIR7. Birth date of deceased (mo., day, yr.) MARCH 1862 6. (c) If alive, give age Exact day unknown years

8. AGE: Years 86 Months 5 Days It less than one day hrs. min.

9. Birthplace Poolesville, Maryland
(Town, county, and State)10. Usual occupation LABORER

11. Industry or business

12. Name Edward Lair
13. Birthplace Poolesville, Maryland14. Maiden name Louisa Lair - Maiden name unknown15. Birthplace Poolesville, Md16. Informant Fleet QuarlesAddress 2309 Michigan Ave17. Burial Date thereof 8-4-48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory MT Zion Mc ChurchLocation Montgomery Hills, Md18. Funeral director Snodden Rockville, Md

Address

19. Aug 4 19 48 Joseph M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 1, 19 48 at 9:30 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ONLY pronounced him dead 8-1-48 19and that I last saw him alive on NEVER SAW him alive 19Immediate cause of death HEART FAILURE DURATIONBoth legs amputated atDue to FREEDMAN'S HOSPITAL BECAUSEOF DIABETIC GANGRENE - WASHINGTONDue to CALVERT LE COMPTON D.C.WASHINGTON, DC

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

SIGNATURE George N. Schultz M.D. M. D. or otherAddress 954 Clarendon Road Date signed 8-1-48Silver Spring, Md

RECEIVED

AUG 5 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

08500

Reg. Dist. No. 246

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7

Hospital, institution, or street address where death occurred:

Suburban Hospital Bethesda MdHow long in hospital or institution? 16 days 4 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. Route # 1
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Bertha Lancaster

3. (b) Social Security Number

4. Sex

F

5. Color or race

C

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Elifton Lancaster6. (c) If alive, give age 40 years

7. Birth date of

deceased (mo., day, yr.)

April 16th 1910

8. AGE:

Years,

Months

Days

If less than one day

384261 1/2 hrs.

min.

9. Birthplace

Montgomery Co.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

William Bonnell

13. Birthplace

Unk.

MOTHER

14. Maiden name

Bertha Bonnell

15. Birthplace

Montgomery Co. Md.

16. Informant

Elifton Lancaster

Address

Suburban Md. Rt 1

17.

(Burial, cremation, or removal, Which?)

Date thereof Aug 27, 1948

(month) (day) (year)

Cemetery or crematory

Sand Hager

Location

Colesville, Maryland

18. Funeral director

R. L. Snowden

Address

Rockville, Md.

19.

(Date rec'd by registrar)

8/27

19.

48Wm E Johns

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 25 19 48 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

AUGUST 8 19 48 to AUGUST 25 19 48and that I last saw him ER alive on AUGUST 25 19 48

Immediate cause of death

HYPOTATATIC PNEUMONIA

DURATION

14 DAYS

Due to

CEREBRO-VASCULARACCIDENT - HEMORRHAGE17 DAYS

Due to

Severe Hypertension3 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

NONE

Date of op.

Autopsy results

NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

JW Pearlman M.D

M. D. or other

Address

Suburban Hospital

Date signed

8-25-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223.

1. PLACE OF DEATH:

County... Montgomery
 City or town... Takoma Park, Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 weeks
 Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital
 How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Montgomery
 City or town... Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 718 Kennebec
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Lawry Clarence L.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Maudie
 7. Birth date of deceased (mo., day, yr.) April 1, 1887 6. (c) If alive, give age..... years
 8. AGE: Years 61 Months 4 Days 14 hrs. min.

9. Birthplace Newton, Kansas
 (Town, county, and state)
 10. Usual occupation Credit-Manager - Retired
 11. Industry or business
 12. Name Lawry, James L.
 13. Birthplace Illinois
 14. Maiden name Humble, Margaret
 15. Birthplace Canada

16. Informant Ella Eckenroth
 Address 718 Kennebec
 17. Burial Date thereof Aug. 17, 1948
 (Burial, cremation, or removal Which?) (month) (day) (year)
 Cemetery or crematory George Washington Mem. Cemetery
 Location Washington, D.C.
 18. Funeral director Arthur J. Talbot
 Address 254 Carroll St., Takoma Park, D.C.
 19. Aug. 15 1948
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Aug 1948 at 4:01 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 July 1948 to 14 Aug 1948
 and that I last saw him alive on 13 Aug 1948
 Immediate cause of death Uremia
 DURATION 1 year
 Due to Chronic glomerular nephritis
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE W.W. Cantor M.D.
210 Tulip Ave., Takoma Park, Md. Date signed 8-14-48
 Address.....

RECEIVED

AUG 17 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 5 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 1 month, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State D. C. County Washington
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 300 F St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war Sp. Am.

3. (a) FULL NAME

LEE, Edward Avery

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 20, 1882 8. (c) If alive, give age 66 years

8. AGE: Years 66 Months 3 Days 5 If less than one day hrs. min.

9. Birthplace Mo. (Town, county, and state)

10. Usual occupation unemployed

11. Industry or business

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant stepson; Mr. Lamar Sasser

Address 300 F St., N.W., Wash., D.C.

17. burial Date thero Aug. 26, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Boneventure

Location Savannah, Ga.

18. Funeral director W. H. CHAMBERS

Address 1400 Chapin St., N. W., Wash., D.C.

19. 8-25-48 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 19 48 at 12:05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 July 19 48, to 25 Aug. 19 48
and that I last saw him alive on 25 August 19 48

Immediate cause of death Coronary Thrombosis, Acute DURATION

Due to Coronary Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Manner of injury Injured at work?

D. L. Burnham

23. SIGNATURE D. L. BURNHAM, Lt JG MC USN M. D. or other

Address USNH Bethesda, Md. Date signed 8-25-48

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08502

94a

RECEIVED

AUG 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08503

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D.C. County _____
 City or town Washington, D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1221 25th St., N. W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war WWII

3. (a) FULL NAME

Burton Carlisle LEFTRIDGE

3. (b) Social Security Number

4. Sex male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced separated
 6. (b) Name of husband or wife Beatrice Leftridge
 7. Birth date of deceased (mo., day, yr.) August 16, 1906 6. (c) If alive, give age _____ years
 8. AGE: Years 41 Months 11 Days 21 It less than one day _____ hrs. _____ min.

9. Birthplace Washington, D. C.
 (Town, county, and state)
 10. Usual occupation Government Printing Office
 11. Industry or business _____
 12. Name LEFTRIDGE, Harry
 13. Birthplace Wash., D.C.
 14. Maiden name JOHNSON, Beth
 15. Birthplace Virginia

16. Informant wife: Mrs. Beatrice Leftridge
 Address #2 Logan Circle, N.W., Apt. 127, Wash., D.C.
 17. burial Date thereof 8-11-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Virginia
 18. Funeral director Ambrose B. Boyd
 Address 1238 20th St., NW, Washington, D.C.
 19. 8-7- 19 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 August 19 48 at 10:20A M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 August 19 48 to 7 August 19 48
 and that I last saw him alive on 7 August 19 48
 Immediate cause of death Bronchopneumonia DURATION 2 days
 Due to Cirrhosis of Liver
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE H. R. COOPER, Lt. MC USN M. D. or other 8-7-48
 Address USNH Bethesda, Md. Date signed _____

RECEIVED

AUG 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

EVIDENCE FOR CHANGE
OF MOTHER'S NAME SHOWN ON:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08504

159

Reg. Dist. No.

216

FILM No. G 117 SEP 29 1948

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Montgomery Bethesda

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days - 11 hrs 5 min

Hospital, institution, or street address where death occurred:

Suburban Hospital 2 days - 11 hrs 5 min

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County MONT.City or town CHEYV CHASE
(If outside city or town limits, write RURAL and give nearest town)Street No. 4600 CHEYV CHASE BLVD
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Louise ANN Selman (TWIN #2)

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Infant

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1948 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 19 1948 to August 22 1948
and that I last saw her alive on August 21 1948

Immediate cause of death

Prematurely

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Bethesda, Md. Date signed 8/25/48

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 19 - 1948

8. AGE:

Years

Months

Days

If less than one day

00211 hrs.5 min.9. Birthplace Suburban Hospital Bethesda, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address 4600 Chevy Chase Blvd., Ch. Co. Md.17. Cremation Date thereof Aug 23, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 8/27 48 Jm E Jones
(Date rec'd by registrar) Registrar

RECEIVED
SEP 1 1948
BUREAU V. 8.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age of mother's name shown on: is especially important. Physicians: please write the causes of death clearly and legibly.

EVIDENCE FOR CHANGE OF MOTHER'S NAME SHOWN ON: MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

08505

159

No. G 117 SEP 29 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH

County Mont. Co.
City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days + 2 hrs
Hospital, institution, or street address where death occurred
Suburban Hosp. Bethesda

How long in hospital or institution? 2 days + 2 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Mo. County Mont.
City or town CHEY CHASE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4600 CHEY CHASE RD.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Jack Alan Lehman

(TWIN #1)

3. (b) Social Security Number

4. Sex

M.

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Infant

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Aug 19 1948

8. AGE:

Years

Months

Days

If less than one day

0022 hrs.

min.

9. Birthplace

Suburban Hosp Bethesda Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Jack E Lehman

13. Birthplace

Louisiana

14. Maiden name

Barbara Carter

15. Birthplace

Virginia

16. Informant

Father: Jack E. Lehman

Address

4600 Chey Chase Blvd, Ch. Ch. Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

Aug 23 1948
(month) (day) (year)

Cemetery or crematory

Suburban Hospital

Location

Bethesda Md

18. Funeral director

Address

E. B. Salom, Sept

19.

(Date rec'd by registrar)

8/27 48Wm E Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1948, at 1:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 19 1948, to Aug 22 1948and that I last saw him alive on Aug 21 1948

Immediate cause of death

Prematurity

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

-PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

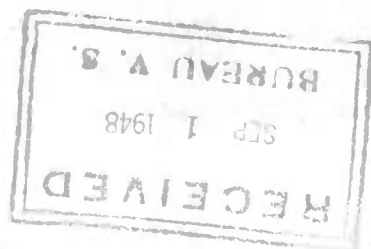
23. SIGNATURE

Paul H. Jones

M. D. or other

Address

Bethesda MdDate signed 8/22/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08506 714

1. PLACE OF DEATH:

County... MONTGOMERY COUNTY
 City or town... SILVER SPRING, MD.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 6 DAYS
 Hospital, institution, or street address where death occurred:
10,000 GEORGIA AVE (HOME)
 How long in hospital or institution?... 6 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... MARYLAND County... MONTGOMERY
 City or town... SILVER SPRING
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 10,000 GEORGIA AVE
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

MISS LOA VIE LENDRUM.

3. (b) Social Security Number

4. Sex

MALE

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

July 5, 1870 (?)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

78 (?)

..... hrs. min.

9. Birthplace... WILKES BARRE, PA.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER

12. Name

ALEXANDER LENDRUM

13. Birthplace

Pittston, PA.

MOTHER

14. Maiden name

MALVINA WILLIAMS

15. Birthplace

WILKES BARRE, PA.

16. Informant HOWARD T. DAVIS

Address

343 Raleigh St. S.E. - WASH. D.C.

17.

(Burial, cremation, or removal. Which?)

Date thereof

8-24-1948

Cemetery or crematory

Hollenback Cemetery

Location

Hollenback Cemetery

18. Funeral director

Address

706 Pennsylvania Ave. N.W. Wash. D.C.

19.

(Date rec'd by registrar)

1948

Josephine M. Schaeffer

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 23

19

48

at

11:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 6

19

to

Aug 23

19

48

and that I last saw her

alive on

Aug 23

19

48

Immediate cause of death

Cardiac Failure

DURATION

10 days

Due to

Malnutrition & Senility

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Phillips Frohman M.D.

Address

2928 Nichols Ave SE

Date signed

8/23/48

RECEIVED

AUG 25 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

 462 X
 08507
 REG. No. G 117 SEP 23 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery
 City or town... Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 months, 26 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 5 months, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... D.C. County...
 City or town... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3429 Quebec St., N.W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war... WWII ✓

3. (a) FULL NAME

Earl Northington LEWIS

3. (b) Social Security Number

4. Sex... male
 5. Color or race... W-US
 6. (a) Single, married, widowed, or divorced... married
 6. (b) Name of husband or wife... Iva L. Lewis
 6. (c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.)... October 2, 1909
 8. AGE: Years... 38 Months... 10 Days... 18
 If less than one day... hrs. ... min.

9. Birthplace... N.C.
 (Town, county, and state)
 10. Usual occupation... Mechanic
 11. Industry or business...
 12. Name... LEWIS, Doc dec
 13. Birthplace... N.C.
 14. Maiden name... TAYLOR, Henrietta dec
 15. Birthplace... N.C.

16. Informant... wife: Mrs. Iva L. Lewis
 Address... 3429 Quebec St., N.W., Wash., D.C.
 17. burial
 (Burial, cremation, or removal. Which?) Date thereof... (month) (day) (year)
 Cemetery or crematory...
 Location... Solomons, Maryland
 18. Funeral director... Harkness & Son W. Z. Sp
 Address... Mutual, Maryland
 19. 8-20 19 48 Mary C. Patterson
 (Date rec'd by registrar) (State) (Signature) Registrar

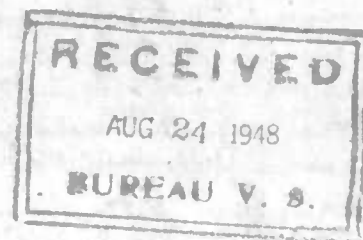
MEDICAL CERTIFICATION

20. DATE OF DEATH... 20 August 19 48 at 10: P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
24 Feb. 19 48 to 20 Aug. 19 48
 and that I last saw him alive on 20 August 19 48
 Immediate cause of death... Bronchopneumonia
Adenocarcinoma of rectum
with intestinal obstruction
 Due to...
 Due to...
 Other conditions...
 (Include pregnancy within 3 months of death)
 Major findings of operations...
 Date of op...
 Autopsy results... confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury... Injured at work?
 23. SIGNATURE... R. C. KESSLER, Lt. JG MC USN
 M. D. or other...
 Address... USNH Bethesda, Md. Date signed... 8-20-48

DURATION
4 days
1 1/2 yrs



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Months
Hospital, institution, or street address where death occurred:
4918 Battery Lane, Chevy Chase, Md.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4918 Battery Lane
(If rural, give LOCATION)
2(a) If veteran, name war No

3. (a) FULL NAME

LAURA V. LIBBEY

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Joseph D. Libbey
7. Birth date of deceased (mo., day, yr.) November 18, 1903 6. (c) If alive, give age 46 years
8. AGE: Years 44 Months 44 Days 8 If less than one day 17 hrs. min.

9. Birthplace Howell, Michigan
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Ara L. Vandercook
13. Birthplace Howell, Michigan
MOTHER
14. Maiden name Alvira S. Reader
15. Birthplace Howell, Michigan

16. Informant Patricia Libbey
Address 4918 Battery Lane, Ch. Ch, Md.
17. Cremation Date thereof Aug 8, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Cedar Hill Crematory
Location Washington, D.C.

18. Funeral director W. Reuben Humphrey
Address Bethesda, Maryland

19. 7/8 19 48 WME J. Leo
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5, 1948 at 8 9 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-22 19 47 to 8-5 19 48
and that I last saw her alive on Aug 4 19 48

Immediate cause of death metastatic carcinoma DURATION Months

Due to lymphosarcoma - Pelvic YEAR

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul D. Clark MD M. D. or other

Address Bethesda Date signed 8-5-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

552

08508

RECEIVED

AUG 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 days
 Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Slate D. C. County
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5343 Broad Branch Rd. N.W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war..... ✓

3. (a) FULL NAME

LOCKHART, Juan Carlos

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mrs. Josefina Sancho deLochart
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) January 15, 1898

8. AGE: Years Months Days It less than one day
50 6 23 hrs. min.

9. Birthplace San Vicente, Provincia, Buenos Aires
 (town, county, and state) Argentina

10. Usual occupation Argentine Navy

11. Industry or business

12. Name Guillermo Rutherford Lockhart

13. Birthplace Argentine

14. Maiden name Elisa Jimenez

15. Birthplace Argentine

16. Informant wife: Mrs. Josefina Sancho deLochart

Address 5343 Broad Branch Rd., N.W., Wash., D.C.

17. burial Date thereof Aug. 13, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location Argentine

18. Funeral director W. W. CHAMBERS

Address 1400 Chapin St., N.W., Wash., D.C.

19. 8-9 18 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 19 48 at 01:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept med Exam. Case 19..... to 19.....
 and that I last saw him alive on 19.....

Immediate cause of death.....

DURATION

Inter-cranial hemorrhage 7 days
fell down cellar steps
(accidental)

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accidental Date of 8-1-48

Where did injury occur? Washington D.C.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury fall Injured at work? no

23. SIGNATURE Frank J. Bruchart M.D.
off med exam M. D. or other

Address Washington Md Date signed 8-8-48

RECEIVED

AUG 10 1918

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08510 159 223

1. PLACE OF DEATH:

County Montgomery
 City or town T. Home Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days 22 hrs 8 min
 Hospital, institution, or street address where death occurred:
Washington same & Hosp.
 How long in hospital or institution? same

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County Carroll, W.C.
 City or town St. Brides
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

LINDA LEE LOWRY

3. (b) Social Security Number

4. Sex Fe 5. Color or race white 6.(a) Single, married, widowed, or divorced _____

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) July 30 1948 6.(c) If alive, give age _____ years

8. AGE: Years _____ Months _____ Days 4 If less than one day 22 hrs. 8 min.

9. Birthplace T. Home Park, Mont. Co., Md.
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Lowry, Orvil Lee13. Birthplace Nashville, Tenn.14. Maiden name Vivian Halley15. Birthplace Mason City, Iowa16. Informant Hospital record

Address _____

17. Burial Date thereof Aug. 5, 1948
 (Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Leg. Kash. Memorial Cem.Location Piggly W. Hyattsville, Md.18. Funeral director Arthur WaffnerAddress 284 Carroll St. Wash. D.C.

19. Aug. 5 1948 Registrar William R. Smith
 (Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-4 1948 at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 July 1948 to 4 Aug. 1948
 and that I last saw him alive on 4 Aug. 1948

Immediate cause of death _____

DURATION

Due to Prematurity

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

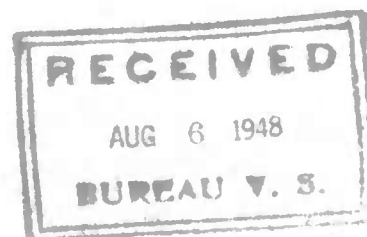
Injured at home, farm, industry, public place (where?) _____

Mans of injury _____ Injured at work? _____

23. SIGNATURE Robert A. Bier, M.D.

M. D. or other

Address 8224 - Ga. av. S.S. Md. Date signed 4 Aug. 48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery
 City or town... Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 17 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution?... 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D.C. County...
 City or town... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 145 D St., S.E.
 (If rural, give LOCATION)
 2. (a) If veteran, name war... WWII

3. (a) FULL NAME

MADDOX, Henry

3. (b) Social Security Number

4. Sex... male
 5. Color or race... negro
 6. (a) Single, married, widowed, or divorced... married

6. (b) Name of husband or wife... Rebecca Maddox
 6. (c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.)... January 25, 1923

8. AGE: Years... 25 Months... 7 Days... 2
 If less than one day... hrs. ... min.

9. Birthplace... Georgia
 (Town, county, and state)

10. Usual occupation... unknown

11. Industry or business

FATHER 12. Name... MADDOX, Willie dec.
 13. Birthplace... Ga.

MOTHER 14. Maiden name... SMITH, Dorothy dec.
 15. Birthplace... Ga.

16. Informant... wife: Mrs. Rebecca Maddox
 Address... 827 Oakview Avenue, Columbus, Ga.

17. burial Removal Date thereof... Aug 31, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory...

Location... Columbus, Ga.

18. Funeral director... W. Ernest Jarvis UETARVIS
 Address... 1432 U St., N.W., Wash., D.C.

19. 8-27 1948 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 27 August 19 48 at 11:30A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
10 August 19 48 to 27 August 19 48
 and that I last saw him alive on 27 August 19 48

Immediate cause of death... Bronchopneumonia DURATION... 1 w k
 Due to... Hypertensive Heart Disease 5 yrs
 Due to... chronic nephritis unknown
 Other conditions...
 (Include pregnancy within 3 months of death)

Major findings of operations...
 Date of op...
 Autopsy results... chronic nephritis, Bronchopneumonia
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury... Injured at work?

23. SIGNATURE... R. L. FLECK, Lt. MC USN
 Address... USNH Bethesda, Md. M. D. or other...
 Date signed... 8-27-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 31 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

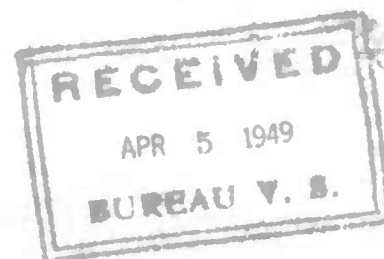
Reg. Dist. No. 714

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montg.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glenmont</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glenmont</u>	
TOWN <u>Glenmont</u>		TOWN <u>Glenmont</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Silver Spring R.F. 5.</u>		STREET ADDRESS (If rural give location) <u>✓</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>William Walter Magruder</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>October 1948</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 26, 1916</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm labor</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>33</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Magruder</u>		14. MOTHER'S MAIDEN NAME <u>Corrie Case</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Laurence Clifton Magruder</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Unknown - Body found in old well.</u>		
Antecedent cause(s) (b) <u>badly decomposed. Had been missing since Aug. 1948.</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>unknown</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Glenmont</u>	(CITY OR TOWN) (COUNTY) (STATE) <u>Montg.</u> <u>md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Sept. med. Exam case</u> , 19....., to <u>Sept. med. Exam case</u> , 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., m., from the causes and on the date stated above.		
SIGNATURE <u>Frank J. Bruchak M.D.</u>		DATE SIGNED <u>3-31-49</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>April 1, 1949</u>
NAME OF CEMETERY OR CREMATORY <u>Burtonsville Union</u>		LOCATION (City, town, or county) (State) <u>Burtonsville, Md.</u>
DATE REC'D BY LOCAL REG. <u>Apr. 1, 1949</u>		REGISTRAR'S SIGNATURE <u>Joseph W. Schaeffer</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Maryland.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 08512 83w 414

1. PLACE OF DEATH:

County MontgomeryCity or town Silver Springs
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, institution, or street address where death occurred:

Care-Lee Rest Home - 15 Phila Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New York CountyCity or town New York
(If outside city or town limits, write RURAL and give nearest town)Street No. 3508 Kings College Pl., Bronx
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Benjamin Marcus

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Separated

6. (b) Name of husband or wife

Sarah Marcus

7. Birth date of deceased (mo., day, yr.)

April 29, 1884

8. AGE: Years Months Days If less than one day

64 hrs. min.

9. Birthplace

Austria
(Town, county, and state)

10. Usual occupation

Wooden cleaver

11. Industry or business

12. Name Israel Marcus13. Birthplace Austria14. Maiden name Uekusari15. Birthplace Austria16. Informant Isaac B. MarcusAddress 1334 Pattenhouse St NW17. New York, N.Y. Date thereof August 23, 1948
(Burial, cremation, or removal of body) (month) (day) (year)

Cemetery or crematory

Location New York, New York18. Funeral director B. W. Wauson, Inc.Address 3501-14 14th St Wash. D.C.19. Aug 23 19 48 Josephine M. Schreff
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1948 at 9:14 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 9, 1948 to Aug 23, 1948and that I last saw him alive on Aug 14, 1948

Immediate cause of death

Cerebral Hemorrhage DURATION 1 yearDue to Malignant HypertensionGeneralized Arteriosclerosis

Due to

Other conditions None

(Include pregnancy within 8 months of death)

Major findings of operations None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Sydney Leventhal, M.D. M. D. or otherAddress 8248 Georgia Ave. Date signed Aug 23, 1948Silver Spring, Md.

RECEIVED

AUG 25 1948

BUREAU F. B. I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08513

Reg. Dist. No. 229

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 hrs 16 min.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? 11 hrs 16 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington D.C. County Washington
 City or town Washington D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1464 Gerard St N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Sam Baby Martinez

3. (b) Social Security Number

4. Sex M 5. Color or race Wx. 6. (a) Single, married, widowed, or divorced —

6. (b) Name of husband or wife —

7. Birth date of deceased (mo., day, yr.) August 25, 1948 6. (c) If alive, give age — years

8. AGE: Years — Months — Days — If less than one day 11 hrs. 16 min.

9. Birthplace Takoma Park, Maryland
 (Town, county, and state)

10. Usual occupation —11. Industry or business —

MOTHER FATHER
 12. Name Rodolfo Martinez
 13. Birthplace Yxtapec Mexico
 14. Maiden name Rebeca Camarena
 15. Birthplace Guadalajara, Mexico

16. Informant Father
 Address Sane

17. Cremation Date thereof Aug 26, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
Crematory

Cemetery or crematory Takoma Park, Md.
 Location Washington Sanitarium & Hosp

18. Funeral director Washington Sanitarium & Hosp
 Address Takoma Park, Md.

19. AUG 28 1948 19 —
 (Date rec'd by registrar) Registrar J. H. Dodd

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26, 1948 at — M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 — to 19 —and that I last saw him — alive on 19 —Immediate cause of death —

DURATION

11 hrs.Due to —Due to —Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE J. H. Dodd M. D. or otherAddress — Date signed —



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 470 08514 214

1. PLACE OF DEATH:

County Montgomery
City or town Burnt Mills, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Colesville, Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Burnt Mills
(If outside city or town limits, write RURAL and give nearest town)Street No. Colesville Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

William T. Milstead

3.(b) Social Security Number

579-05-9947

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MaleWhiteMarried6.(b) Name of husband or wife Mary P.

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 18888. AGE: Years Months Days If less than one day
59 8 19 hrs. min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Supt of Building11. Industry or business Janitor12. Name Delmar Lee Milstead13. Birthplace Maryland14. Maiden name Jeanette Milstead15. Birthplace Maryland16. Informant Mrs Mary P. MilsteadAddress Burnt Mills, Md.17. Burial Date thereof Aug. 5, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cremation Layhill Methodist ChurchLocation Layhill, Mont Co. Maryland18. Funeral director Wanna E. Humphrey, Inc.Address 8434 Ga. Ave. Silver Spring, Md.19. Aug 4 1948 Joseph M. Chaeffle
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 August 1948 at 245P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 July 1948 to 3 August 1948
and that I last saw him alive on 31 July 48

Immediate cause of death

Broncho-genic Carcinoma
of the right lung

DURATION

3 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

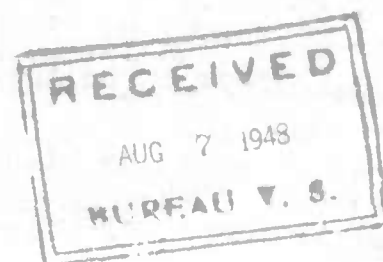
23. SIGNATURE Charles W. Thompson MD
M. D. or otherAddress 1714-N St. NW Date signed 3 Aug 48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2/6

1. PLACE OF DEATH:

County Montgomery Co.City or town Bethesda Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 6-22-48Hospital, institution, or street address where death occurred: Suburban Hosp8600 Old Georgetown Rd. - Bethesda Md.How long in hospital or institution? Since 6-22-48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MontgomeryCity or town Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. #3

(If rural, give LOCATION)

2(a) If veteran, name war No

3. (a) FULL NAME

Mrs Mary Mobley

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband Walter James Mobley6. (c) If alive, give age 34 years

7. Birth date of

deceased (mo., day, yr.) July 27, 1919

8. AGE:

Years

29

Months

0

Days

28

If less than one day

.....hrs.min.

9. Birthplace Gaithersburg Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

None

MOTHER

FATHER

12. Name

Harry Lee

13. Birthplace

Fred. Co., Maryland

14. Maiden name

Effie Payne

15. Birthplace

Leesburg - Loudon Co Va.

16. Informant

Mr. Earl Mobley - Brother-in-law

Address

R.F.D. #1, Rockville, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof August 27, 1948

(month) (day) (year)

Cemetery or crematory

Forest Oak Cemetery

Location

Gaithersburg, Maryland

18. Funeral director

Wm. Andrew Humphrey

Address

Bethesda 14, Maryland

19.

8/26 1948

(Date rec'd by registrar)

Wm E Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-24- 1948, at 9¹⁰ A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med. Exam case 1948, to 1948and that I last saw him alive on 1948

Immediate cause of death

DURATION

Extrem cerebral hemorrhage 2 daysDue to auto accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of 8/21/48Where did injury occur? Gaithersburg Md (City or town) (County) (State)Injured at home, farm, industry, public place (where?) HighwayMeans of injury auto accident Injured at work? noFrank J. Broschart M.D.23. SIGNATURE Dep med Exam M. D. or otherAddress Gaithersburg Md Date signed 8-24-48

08515

170c

2/6

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 28 1948

BUREAU V. S.

08516

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months, 11 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 3 months, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County P.G.
 City or town Hyattsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6202 43rd Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war ☒

3. (a) FULL NAME

MOORE, John William

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) January 4, 1916 6.(c) If alive, give age years

8. AGE: Years 32 Months 7 Days 1 If less than one day hrs. min.

9. Birthplace Mass.
 (Town, county, and state)

10. Usual occupation unemployed

11. Industry or business

12. Name MOORE, John M.13. Birthplace Mass.14. Maiden name BUCKLER, Marguerite15. Birthplace N.Y.16. Informant sister: Mrs. Marguerite GibbonsAddress 6202 43rd Avenue, Hyattsville, Md.

17. burial Date thereof Aug. 9, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. OlivetLocation Washington, D.C.18. Funeral director F. Gasch & SonsAddress Hyattsville, Md.

19. 8-6 19 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 August 19 48 at 2:24 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 April 19 48 to 5 August 19 48
 and that I last saw him alive on 5 August 19 48

Immediate cause of death Tuberculosis, Pulmonary, Rein-
fectect, Active, Far-Advanced

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. R. Mills, Jr., Lt. JG MC USN

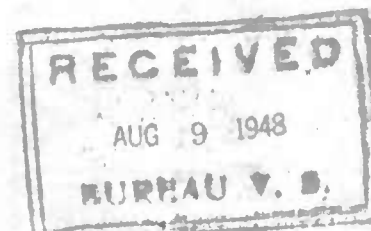
Address USNH Bethesda, Md. Date signed 8-6-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Derby Chase
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 22 yrs

Hospital, institution, or street address where death occurred

How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ✓ County ✓City or town ✓
(If outside city or town limits, write RURAL and give nearest town)Street No. ✓
(If rural, give LOCATION)2.(a) If veteran, name war 720

3. (a) FULL NAME

Thomas P. Moore

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Emeline Moore6.(c) If alive, give age ? years7. Birth date of deceased (mo., day, yr.) Apr 16, 18638. AGE: Years 85 Months 4 Days - If less than one day hrs. min.9. Birthplace DC
(Town, county, and state)10. Usual occupation Printer

11. Industry or business

12. Name Dr. Joseph B. Moore13. Birthplace DC14. Maiden name Amelia Pathman15. Birthplace DC16. Informant Mrs. John B. HillAddress 211 Reformatory St. CC 70817. Cremation Date thereof Aug 15-48
(Burial, cremation, or other) (month) (day) (year)Cemetery or crematory Cedar HillLocation Suitland Md18. Funeral director Frank JayAddress 5406 Bell Ave. NW DC19. 8/15 19 48 John E. Jones

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 19 48 at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/12/48 19 48 to 8/15/48 19 48and that I last saw him alive on 8/14/48 19 48Immediate cause of death Ch. NephritisUremiaDue to Arterio-sclerosisHypertensive Patect

Due to

Other conditions Acute multiple decubiti

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James A. O'Keefe MDAddress 5825-16-N.W.Date signed 8/15/48

2010

1948-8-15

1891

1944

7-20-11

RECEIVED

AUG 18 1943

BUREAU V. B.

2. *Phyllanthus*

20. 7. 1948

3. The general public is not aware of the importance of the environment.

2000-01-01

O. C. ...

100-2-1

24. 10. 1951

08516

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Rockville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 813 Baltimore Rd
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Millie C. ~~Newbury~~ Newberry

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Jesse Newberry

7. Birth date of deceased (mo., day, yr.)

Sept. 1874

6. (c) If alive, give age

77 years

8. AGE:

Years

Months

Days

If less than one day

73

11

?

hrs.

min.

9. Birthplace

Mechanicsburg, Va.

10. Usual occupation

Housewife

11. Industry or business

Jim Stafford

12. Name

Mechanicsburg, Va.

14. Maiden name

Melvin

15. Birthplace

Mechanicsburg, Va.

16. Informant

Paul W. Newberry

17. (Burial, cremation, or removal, Which?)

Burial-Transit

Cemetery or crematory

Mechanicsburg, Cemetery

Location

Mechanicsburg, Virginia

18. Funeral director

Wm. Ransom Pumphrey

Address

Bethesda 14, Maryland

19. (Date rec'd by Registrar)

8/12 48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug - 11, 1948, at 10:35 P. M.

I CERTIFY that death occurred on the date above stated: that I attended deceased from

8/8 to 8/11 1948

and that I last saw h. CR alive on August 11, 1948

Immediate cause of death

Congestive heart failure

DURATION

6 wks

Due to

Hypertensive arterio-sclerotic heart disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Ransom Pumphrey, M.D.

Address

Rockville, Md.

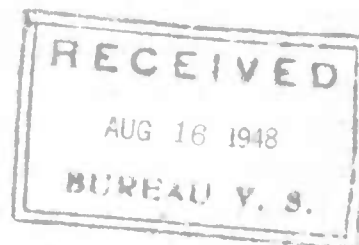
Date signed

8/11/48

MARGIN RESERVED FOR BINDING

VS A15 9.45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 319 D St., N.E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war WWI

3. (a) FULL NAME

NOLAN, George Thomas

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Beatrice V. Nolan
 6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) August 24, 1897
 8. AGE: Years 50 Months 11 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D.C.
 (Town, county, and state)

10. Usual occupation unknown

11. Industry or business _____

MOTHER 12. Name NOLAN, Dennis dec.

13. Birthplace Wash., D.C.

14. Maiden name DOWNEY, Nellie dec.

15. Birthplace Wash., D.C.

16. Informant wife: Mrs. Beatrice V. Nolan

Address 319 D St., N.E., Wash., D.C.

17. burial Date thereof 8-9-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director W. W. CHAMBERS JAB

Address 517 11th St., S.E., Wash., D.C.

19. 8-6 19 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 August 19 48 at 5:19 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 July 19 48 to 5 August 19 48
 and that I last saw him alive on 5 Aug 48

Immediate cause of death infarction, pulmonary DURATION 5 days

Due to Valvular Heart Disease
aortic insufficiency unknown

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results Pulmonary infarction; aortic insufficiency

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

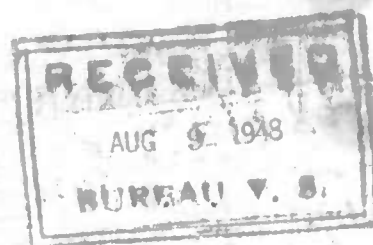
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE R. L. FLECK, Lt. MC USN M. D. or other _____

Address USNH Bethesda, Md. Date signed 8-6-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08524 217

1. PLACE OF DEATH:

County Montgomery Co.City or town Spencer, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:

Montgomery County General HospitalHow long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Spencerville
(If outside city or town limits, write RURAL and give nearest town)Street No. On back of Campbell's Store
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

WILLIAM NOKKIS

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan 10th - 1873

6. (c) If alive, give age years

8. AGE:

75

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace Baltimore Co. Maryland
(Town, county, and state)10. Usual occupation none11. Industry or business none12. Name Charles Nokkis13. Birthplace Unk.14. Maiden name Violet15. Birthplace Unk.16. Informant Annie TaylorAddress Spencerville, Md17. Burial Date thereof Aug 10 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Round OakLocation Spencerville, Md18. Funeral director R. L. SpawlineAddress Rockville, Md19. Aug 10 19 48 Leah B. Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6, 19 48 at 4:25 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 31, 19 48 to August 6, 19 48
and that I last saw him alive on August 6 19 48

Immediate cause of death

Cerebral Hemorrhage

DURATION

8 hoursDue to Hypertensive Cardiac
vascular disease4 years

Due to

Other conditions Diabetes Mellitus
Dwarfism
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

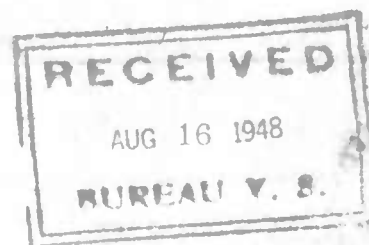
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles H. Hagen M. D. or otherAddress Sandy Spring, Md Date signed 8/10/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08521 223 274

1. PLACE OF DEATH:

County Montgomery CountyCity or town Sakoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 16 1/2 days

Hospital, institution, or street address where death occurred:

Wash. San. Ins. Hosp. Prince Geo. Co. Md.How long in hospital or institution? 16 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Chesapeake
(If outside city or town limits, write RURAL and give nearest town)Street No. 934 Thornapple St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mr. Charles H. Payne

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 18818. AGE: Years 67 Months 6 Days — If less than one day
hrs. min.9. Birthplace King George Co. Virginia
(Town, county, and state)10. Usual occupation Retired Food Merchant

11. Industry or business

12. Name John R. Payne13. Birthplace King Geo. Co. Virginia14. Maiden name Spah & Crapley15. Birthplace King Geo. Co. Virginia16. Informant Washington Sanitarium RecordsAddress Sakoma Park, Md.17. Burial Date thereof AUG. 23, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar HillLocation Suitland, Prince Geo. Co., Md.18. Funeral director Wanner & Humphrey, Inc.Address 8434 Ga. Ave. Silver Spring, Md.19. Aug 23 19 48
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 19 48 at 11:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 1946 to Aug 20 19 48and that I last saw him alive on Aug 20 19 48Immediate cause of death Conjunctive Cardiac FailureDURATION TerminalDue to Carcinoma of the Liver 1 yr

(Secondary)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Cuprin above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert A. Hare MD.Address Sakoma Park, Md. Date signed 8/21/48

M. D. or other

Date signed

MARGIN RESERVED FOR BINDING

I

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 24 1948

BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

94a 08522
Reg. Dist. No. 214

1. PLACE OF DEATH
County Montgomery Co
City or town Silver Spring Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 hour
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Washington DC County DC
City or town DC
(If outside city or town limits, write RURAL and give nearest town)
Street No. 771 Kensington DC
(If rural, give LOCATION)
2.(a) If veteran, name war WW

3. (a) FULL NAME
Joseph Wilson Prather

3. (b) Social Security Number

4. Sex Male 5. Color or race Cauc 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Lillian Mae Prather
6.(c) If alive, give age 57 years
7. Birth date of deceased (mo., day, yr.) April 29 - 1890

8. AGE: Years 58 Months 3 Days 30 If less than one day
hrs. min.

9. Birthplace Lyonsville Mo
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Home Ex Stores

12. Name Joseph Prather

13. Birthplace Maryland

14. Maiden name Ernie Simpson

15. Birthplace Maryland

16. Informant Lillian Mae Prather

Address 771 Kensington St Was DC

17. Burial Date thereof Aug 31 - 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brook Grove Md

Location Lyonsville Md.

18. Funeral director Box W. Barber

Address Lyonsville Md.

19. Aug 30 19 48 Josephine Schaeffer
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 19 48 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1st med exam to 19

and that I last saw him alive on 19

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Brochant M.D.
1st med exam M. D. or other

Address Washington DC Date signed 8-28-48

DURATION
1st med exam
ending

RECEIVED

SEP 2 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

305 Philadelphia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 305 Philadelphia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

GERTRUDE SCHERR RENNINGER

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife Julius C. Renninger

May 14 - 1874 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14 - 1874

8. AGE: Years Months Days If less than one day

74 2 21 hrs. min.9. Birthplace Washington, D.C.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Julius Scherr13. Birthplace Switzerland14. Maiden name Emilie Sievers15. Birthplace Washington, D.C.16. Informant Julius C. RenningerAddress 305 Philadelphia Ave.17. Burial Date thereof 18-7-1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Oakland CemeteryLocation Oakland, Maryland18. Funeral director S. H. Hines Co.Address 2901-14th St., N.W., D.C.19. Aug 5 19 48 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5th Aug 19 48 at 8⁰⁰ A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10th April 19 48 to 5th Aug 19 48and that I last saw him alive on 30th July 19 48

Immediate cause of death

Myocardia

DURATION

Due to Myocardial Coronary DiseaseDue to Coronary Artery DiseaseOther conditions Myocardial Damagesecondary to old Coronary Artery Disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John G. Kander
1726 M. A. N. W. M. D. or other
Address Date signed 8/5/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

RECEIVED

AUG 6 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MONTGOMERY Montgomery
 City or town BETHESDA Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred Suburban Hosp.8600 Old Georgetown Rd. Bethesda

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Takoma Park, Md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 504 Greenwood Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Raymond Samuel Rife

3. (b) Social Security Number

578-12-1142

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

MARRIED Married6. (b) Name of husband or wife Mildred Abell

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

April 27, 1906

8. AGE:

Years

Months

Days

If less than one day

4241

.....hrs.min.

9. Birthplace Takoma Park, Md.

(Town, county, and state)

10. Usual occupation Contractor

11. Industry or business

12. Name Charles A. Rife13. Birthplace Harrisburg, Pa.14. Maiden name Cora Walmer15. Birthplace Pa.16. Informant Mildred A. RifeAddress 504 Greenwood Ave., Tak. Pk., Md.17. Burial Date thereof Aug. 31, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Washington Mem. Park Inc.Location Prince George Co., Md.18. Funeral director Warner E. Humphrey, Inc.Address Silver Spring, Md.19. 8/30/48 19 48

(Date rec'd by registrar)

Mr E Jones
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 August 19 48 at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 April19 46to 28 Aug.19 48and that I last saw him alive on 28 Aug. 19 48

Immediate cause of death

Congestive Heart Failure

DURATION

3 DaysDue to Cardiac Enlargement2 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

M. D. Queen M. D.

M. D. or other

Address Takoma Park, Md.Date signed 8-28-48

RECEIVED

SEP 7 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Georgia County _____
City or town Atlanta
(If outside city or town limits, write RURAL and give nearest town)
Street No. 310 6th St., N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war Sp. Am. WWI & II

3.(a) FULL NAME

ROPER, Walter Gordon

3.(b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced divorced

6.(b) Name of husband or wife Mrs. Robert V. Roper

7. Birth date of deceased (mo., day, yr.) October 18, 1875 6.(c) If alive, give age _____ years

8. AGE: Years 72 Months 2 10 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace Georgia
(Town, county, and state)

10. Usual occupation Retired Navy

11. Industry or business _____

12. Name ROPER, Joel Cole dec. _____

13. Birthplace S.C.

14. Maiden name GORDON, Mary dec. _____

15. Birthplace Ga.

16. Informant son: Mr. Walter Gordon Roper, Jr.
Address 310 6th St., N.E., Atlanta, Ga.

17. burial removal Date thereof Aug. 27, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location Atlanta, Georgia

18. Funeral director S. H. HINES W. Mitchell

Address 2901 14th St., N.W., Wash., D.C.

19. 8-27- 1948 Mary C. Patterson
(Date rec'd by registrar) (Month) (Day) (Year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 August 19 48, at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 August 19 48, to 27 August 19 48.

and that I last saw him im. alive on 27 August 19 48.

Immediate cause of death Cerebral Hemorrhage DURATION 2 1/2 mons

Due to Arteriosclerosis 10 yrs.
generalized

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. E. Nardini E. NARDINI, Cdr. MC USN

Address USNH Bethesda, Md. Date signed 8-27-48

08525

83a

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the event age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 31 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 2807-27th St., N.W.
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

CHARLES WINFIELD ROSS

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Estella M. Ross

7. Birth date of deceased (mo., day, yr.)

Oct. 16 1877

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

2010

hrs.

min.

9. Birthplace

Buckeye City, Knox Co. Ohio
(Town, county, and state)

10. Usual occupation

Chiropractor

11. Industry or business

Glor

MOTHER FATHER

12. Name

Alonso J. Ross

13. Birthplace

Buckeye City Ohio

14. Maiden name

Edith Steer

15. Birthplace

Brink, Haven Ohio

16. Informant

Hospital Records

Address

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof

8/14/48
(month) (day) (year)

Cemetery or crematory

St. Lumen

Location

The A. H. Hines Co.

18. Funeral director

Address

2901-14th St., N.W. D.C.

19.

8/12
(Date recd by registrar)

19

48

19

48Wm E Jones
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 19 48, at 5:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 Aug 19 48, to 17 Aug 19 48and that I last saw him alive on 11 Aug 19 48Immediate cause of death Arteriosclerotic heart diseaseDURATION Not known

Due to

Due to

Other conditions Aproteinaemia &nutrition & edema

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm E JonesAddress 9601 Linton Pl.Date signed 8-12-48

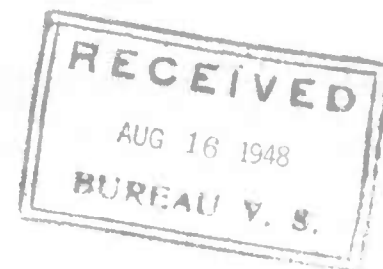
M. D. or other

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 08527 223

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Washington Sanitarium + Hospital
 How long in hospital or institution? 2 days - 12 hours 20 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1027 Flower Ave
 (If rural, give LOCATION)
 2. (a) if veteran, name war no

3. (a) FULL NAME

Ruben, Mrs Violet G

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

Cauc

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife

Arthur Ruben8. (c) If alive, give age Dec years

7. Birth date of deceased (mo., day, yr.)

December 21, 1867

8. AGE:

Years

Months

Days

If less than one day

8082

hrs.

min.

9. Birthplace

Salt Lake City - Utah
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER

12. Name

Robert Gray

13. Birthplace

Scottham

14. Maiden name

Jessie McComie

15. Birthplace

Scottham

16. Informant

Washington Sanit Hosp. Records

Address

Takoma Park - Washington D.C.

17.

Removal

Date thereof

Aug 23, 1948
(month) (day) (year)

Cemetery or crematory

Bethesda Md.

Location

Wm Ruben Humphrey

18. Funeral director

Bethesda Md.

Address

19.

Aug 23

19.

48G. W. Wadley

Registrar

23. SIGNATURE

J. Marshall Cawiller Jr. M.D.

Address

8648 GEORGIA AVE.23 AVE. 48

Date signed

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 AUGUST 19 48 at 1:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

NOVEMBER 19 47 to 23 AUG 19 48and that I last saw her alive on 23 AUG 19 48Immediate cause of death CORONARY THROM-
BOSIS

DURATION

Due to ARTERIO SCLEROSISDue to DIABETES MELLITUSOther conditions NONE

(Include pregnancy within 3 months of death)

Major findings of operations NONEDate of op. NONE

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

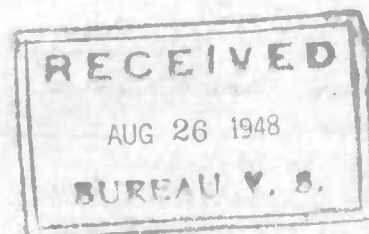
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?



PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Cabin John Park
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, institution, or street address where death occurred:

McArthur Blvd. & Persimmon Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MontgomeryCity or town Cabin John Park
(If outside city or town limits, write RURAL and give nearest town)Street No. McArthur Blvd. & Persimmon Lane
(If rural, give LOCATION)

2(a) If color, name war

3. (a) FULL NAME

ETTASCHULTZ

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

William Schultz

7. Birth date of deceased (mo., day, yr.)

Nov. 30, 1870

6. (c) If alive, give age..... years

8. AGE:

Years

77

Months

2

Days

29

If less than one day

hrs.

min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

James Burn

13. Birthplace

Washington, D.C.

14. Maiden name

Unk.

15. Birthplace

Washington D.C.

16. Informant

James P. Hill

Address

1712-Mass Ave. S.E.

17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Cedar Hill

Location

18. Funeral director

The S. H. Hines Co.

Address

2901-14th St. N.W. Wash. D.C.

19.

(Date rec'd by registrar)

9/1/48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1948 at 8:52 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 28 1948 to Aug 31 1948and that I last saw her alive on Aug 31 1948

Immediate cause of death

Cerebral hemorrhage

DURATION

Due to

Senility

Due to

Dehydration

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. A. A. Dean

M. D. or other

Address 4617 East Park Hwy. N.W. Date signed 9-1-48

RECEIVED

SEP 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County MontgomeryCity or town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County MontgomeryCity or town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)Street No. Route 13
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Richard Sewell

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Letty Sewell6. (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.)

August - 1st - 1863

8. AGE:

Years 85Months 0Days 2

If less than one day

4 hrs. 4 min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

farmer

11. Industry or business

farm

FATHER

12. Name

Richard Sewell

13. Birthplace

unknown

MOTHER

14. Maiden name

unknown

15. Birthplace

Maryland

16. Informant

Letty Sewell

Address

Gaithersburg, Md. R-317. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Aug 7, 1948
(month) (day) (year)

Cemetery or crematory

Lincoln Park,

Location

Rockville, Md

18. Funeral director

R. H. Snowden

Address

Rockville, Md19. Dr

(Date rec'd by registrar)

19. 48Alma H. Carter
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August - 4 - 1948 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July - 20 - 1948 to Aug - 4 - 1948
and that I last saw him alive on Aug - 12 - 1948

Immediate cause of death

senility

DURATION

4-5 years

Due to

Due to

Other conditions

senile dementia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

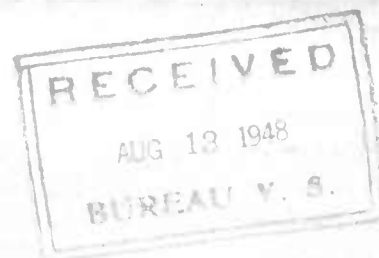
William C. Miller, M.D.

M. D. or other

Address

Gaithersburg, MdDate signed 8/4/48

48
51



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 416 6th St., N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war WWI

3. (a) FULL NAME

SILLERY, Robert

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) March 14, 1896 6. (c) If alive, give age _____ years

8. AGE: Years 52 Months 5 Days 16 If less than one day _____ hrs. _____ min.

9. Birthplace Ill.
 (Town, county, and state)

10. Usual occupation unemployed

11. Industry or business _____

FATHER 12. Name SILLERY, John dec.

13. Birthplace Ill.

MOTHER 14. Maiden name IXONS, Mary dec.

15. Birthplace Ill.

16. Informant (no next of kin known)

Address Veterans give us above information)

17. burial Date thereof 9-1-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director W. W. Chambers

Address 1400 Chapin St., N. W., Wash. D.C.

19. 8-30 148 Mary C. Patterson
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 August 1948 at 3:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 August 1948 to 30 August 1948
 and that I last saw him im alive on 30 August 1948

Immediate cause of death Edema, Lung DURATION _____

Due to Cirrhosis of liver atrophic

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

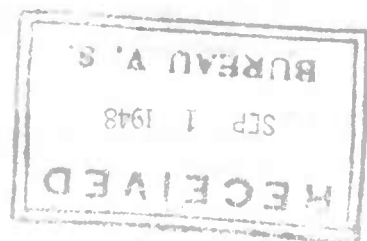
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

L. E. Watters, Jr.
L. E. WATTERS, Jr., Lt. JG MC USN

23. SIGNATURE _____ M. D. or other _____

Address USNH Bethesda, Md. Date signed 8-30-48



Coroner called. Re leased Body

PLEASE WRITE PLAINLY, WITHOUT FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 10 Hours 20 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda (14)
(If outside city or town limits, write RURAL and give nearest town)Street No. Route # 3
(If rural, give LOCATION)2.(a) If veteran, name war World War I

3. (a) FULL NAME

Eli C Smith

3. (b) Social Security Number

None

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Annie L. Smith

7. Birth date of deceased (mo., day, yr.)

Jan. 1894

6. (c) If alive, give age. years

8. AGE:

Years

Months

Days

If less than one day

54714

hrs.

min.

9. Birthplace

North Carolina
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER
MOTHER

12. Name

Jacob C Smith

13. Birthplace

North Carolina

14. Maiden name

Laura Smith

15. Birthplace

Unknown

16. Informant

Family

Address

17. Burial

Date thereof August 31, 1948

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Arlington National Cemetery

Location

Arlington, Virginia

18. Funeral director

WM. Landon Ramsey

Address

Bethesda, Maryland

19.

8/29
(Date rec'd by registrar)19. 48Wm E Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26, 1948 at 8:50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

25 Aug 1948 to Aug 26 1948and that I last saw him alive on Aug 24 1948Immediate cause of death Auto Ventricularfailure -> Preliminary examDue to Generalized myocardialDamagesDue to Coronaries of heart

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

NO OP

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

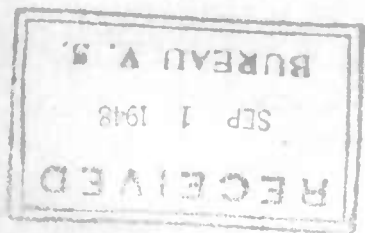
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Oliver G. H. H. H.Address Suburban Hosp, Bethesda, Md. Date signed 8/29/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

223-

1. PLACE OF DEATH:

County MontgomeryCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

608 Carroll av.How long in hospital or institution? 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County W.C.City or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 817 Madison St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Florence M. Smith

3. (b) Social Security Number

4. Sex Female5. Color or race white6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife John Smith

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 18738. AGE: Years 74 Months 10 Days 20 If less than one day hrs. min.9. Birthplace Cumberland, Md.

(Town, county, and state)

10. Usual occupation Gov. Employee11. Industry or business Retired12. Name Jacob. Scherer13. Birthplace Germany14. Maiden name Lophie Underwood15. Birthplace Germany16. Informant Herbert. S. SmithAddress 817 Madison St. N.W. Wash. D.C.17. Burial Date thereof Aug. 10, 1948

(Burial, cremation, or removal Which?)

Cemetery or crematory GreenwoodLocation Wash. D.C.18. Funeral director The S. H. Fine Co.Address 2901-14th St. S.W. Wash. D.C.19. Aug-8 19 48 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 19 48 at 11:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15 19 45 to Aug 7 19 48and that I last saw him alive on Aug 7 19 48Immediate cause of death Cerebral hemorrhage DURATION 2 daDue to Hypertension 20 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur Lewis MD M. D. or otherAddress 1714 R. I. Ave. N.W. Date signed 8/8/48

RECEIVED

AUG 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08533 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital Bethesda, Md.
 How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County Washington
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 240 2nd St. N.E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war WWI

3. (a) FULL NAME

SMITH, Shields

3. (b) Social Security Number

4. Sex male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced separated

6. (b) Name of husband or wife Mrs. Corrinne Smith

7. Birth date of deceased (mo., day, yr.) July 4, 1886 6. (c) If alive, give age years

8. AGE: Years 62 Months 1 Days 17 If less than one day hrs. min.

9. Birthplace La. (Town, county, and state)10. Usual occupation unemployed

11. Industry or business

12. Name SMITH, Hyman dec13. Birthplace La.14. Maiden name unknown15. Birthplace unknown16. Informant Friend: Mrs. Patsy MitchellAddress 240 2nd St., N.E., Wash., D.C.

17. burial Date thereof 8-26-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington NationalLocation Arlington, Virginia18. Funeral director W. Ernest Jarvis E.W.J.Address 1432 U St. N.W., Wash., D.C.

19. 8-23 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 August 19 48 at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 August 19 48 to 21 Aug. 19 48
 and that I last saw him alive on 21 August 19 48

Immediate cause of death bronchopneumonia DURATION 24 hrs

Due to Bronchial asthma

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. E. Marland, Jr. Lt JG MC USNAddress USNH Bethesda, Md. Date signed 8-23-48

RECEIVED

AUG 25 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

77d

08534

1. PLACE OF DEATH:

County MONTGOMERY
City or town BETHESDA
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
100 Lucas Lane
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 100 Lucas Lane
(If rural, give LOCATION)
2(a) If veteran, name war No

3. (a) FULL NAME

JOHN W. SNOWDEN

3. (b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife Elizabeth W. Snowden
7. Birth date of deceased (mo., day, yr.) June 23, 1908
8. AGE: Years 40 Months 40 Days 1 If less than one day 15 hrs. min.

9. Birthplace Hallifax, England
(Town, county, and state)

10. Usual occupation C.P.A.

11. Industry or business

12. Name Arthur Snowden

13. Birthplace England

14. Maiden name Eliza Ann Jennings

15. Birthplace England

16. Informant Arthur Snowden-Father
Address

17. Burial Date thereof August 12, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rock Creek Cemetery
Location Washington, D. C.

18. Funeral director Wm. L. Landon, Pumphrey
Address Bethesda 14, Maryland

19. 8/12 19 48 Wm E Jones
(Date signed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH About Aug 7 19 48 at 1 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sup med exam case 19 10 and that I last saw him alive on 19 10

Immediate cause of death unknown
Body badly decomposed
History of chronic
alcoholism

Due to found dead in bed at home

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations. Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work?

23. SIGNATURE Frank J. Bruchman M.D.
Sup med exam M. D. or other

Address Garfieldburg Md Date signed 8-10-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 14 1948

BUREAU V. 8.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, institution, or street address where death occurred:
Montgomery County General Hospital
How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville (If outside city or town limits, write RURAL and give nearest town)
Street No. Norbeck
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

LEWIS STEWART

3. (b) Social Security Number

4. Sex M. 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 21 1872 6.(c) If alive, give age 76 years

8. AGE: Years 76 Months 0 Days 23 If less than one day hrs. min.

9. Birthplace Falls Church, Fairfax, Virginia
(Town, county, and state)

10. Usual occupation Retiree

11. Industry or business William Stewart

12. Name Virginia

13. Birthplace Virginia

14. Maiden name Adeline Williams

15. Birthplace Virginia

16. Informant Rebecca Smith (sister)

Address Rockville RFD#3, Md.

17. Burial Date thereof Aug. 14, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory 2 Baptist Church

Location Falls Church, Va.

18. Funeral director Robert L. Snowden

Address 246-N. Wash. St. Rockville

19. Aug 14 1948 Gertrude B. Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1948 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/13 1948, to 8/12 1948

and that I last saw him alive on 8/11 1948

Immediate cause of death Cachexia

DURATION 2 mo

Due to Urthral Stricture 1 yr

Due to Carcinoma of Prostate 2 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

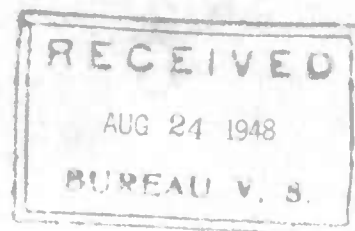
23. SIGNATURE C. H. Sign M. D. or other

Address Sandy Spring, Md. Date signed 8/12/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County MONTGOMERY
City or town OLNEY
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8/14/48 - 8/29/48 15 days
Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital, Inc.
How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY
City or town Sandy Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Anna Belle Stream

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife _____
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) September 27 1869
8. AGE: Years 78 Months 11 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Lucketts Virginia
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business _____
12. Name William Stream
13. Birthplace Virginia
14. Maiden name Mary Ann Frye
15. Birthplace Virginia

16. Informant Hospital Records
Address Montgomery County General - Olney Md.
17. Burial Date thereof 9-1-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Burtonville, Md.
Location Burtonville, Md.
18. Funeral director Ray W. Barber
Address Laytonsville, Md.
19. 8-30 1948 Bertie B. Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1948 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/11 1948 to 8/29 1948
and that I last saw him alive on 8/29 1948

Immediate cause of death acute cardiac failure DURATION 1 day

Due to Coronary Occlusion today

Due to _____
Other conditions acute cholecystitis

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE Lawler M. D. or _____
Address Sandy Spring, Md. Date signed 8/30/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 131a 08537 46

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Chevy Chase
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 325 Essex Ave.,
 (If rural, give LOCATION)

2. (a) If veteran, name war:

3. (a) FULL NAME

JESSE E. SWIGART

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Rebecca D. Swigart6. (c) If alive, give age 48 years7. Birth date of deceased (mo., day, yr.) Aug., 27, 1873

8. AGE: Years 74 Months 0 Days 0 If less than one day 0 hrs. 0 min.

9. Birthplace Ind. (Town, county, and state)10. Usual occupation Retired11. Industry or business U.S. Gov't.12. Name Frank Swigart13. Birthplace Unk.14. Maiden name Margarite Klein,15. Birthplace Unk.16. Informant Mrs. Laura J. Hess,Address 327 Essex Ave., Chevy Chase, Md.17. Burial Date thereof Aug. 11, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Oak Hill CemeteryLocation Washington, D.C.18. Funeral director Chevy Chase Funeral HomeAddress 5101 Wis., Ave., N.W.19. 8/9 48 Wm E. Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1948 at 10:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 21 1948 to Aug 9 1948and that I last saw him alive on August 8 1948Immediate cause of death CerebralThrombosis

DURATION

4.5 hrs.Due to Cerebro-vascularrenal disease withDue to Hypertension3 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William E. Jones M. D. or otherAddress 3271 Livingston St. Date signed 8-9-48

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
AUG 14 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 940 08538 216

1. PLACE OF DEATH:

County Montgomery
City or town Glen Echo
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

4462 MacArthur Blvd.

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Glen Echo
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4462 MacArthur Blvd.

(If rural, give LOCATION)

Unknown

2.(a) If veteran, name war...

3. (a) FULL NAME

MALCOLM H. TALBOTT

3. (b) Social Security Number

215-07-4009

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Elizabeth E. Talbott

6. (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 24th, 1910

8. AGE:	Years	Months	Days	If less than one day
<u>38</u>	<u>38</u>	<u>0</u>	<u>20</u>	<u>—</u> hrs. <u>—</u> min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation Repairman of radiators

11. Industry or business As above

12. Name Joseph H. Talbott

13. Birthplace Washington, D.C.

14. Maiden name Eva Howser

15. Birthplace Washington, D.C.

16. Informant Mrs. Elizabeth E. Talbott

Address Glen Echo, Maryland

17. Removal Aug. 15, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Funeral Home

Location Washington, D.C.

18. Funeral director W.W. Chambers Co.

Address 3072 - M Street, N.W., Wash., DC

19. 8/16 19 48 Wm E. Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14th, 1948 at 11:55P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him 19 alive on 19

Immediate cause of death DEP. MED. EXAM. CASE DURATION

Cornary occlusion Died Suddenly

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op.

Autopsy result No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank J. Brochert M.D.

Dep. Med. Exam.

M. D. or other

Address Gaithersburg, Md. Date signed 8/15/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

08539

48a1

1. PLACE OF DEATH:

County..... Montgomery
 City or town..... Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 2 months, 13 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution?..... 2 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Va. County.....
 City or town..... Norfolk
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 7406 Shirland Avenue
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war.....

3. (a) FULL NAME

TOMPKINS, Emile DaVal

3. (b) Social Security Number

4. Sex..... female 5. Color or race..... W-US 6.(a) Single, married, widowed, or divorced..... widowed
 6.(b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.)..... July 16, 1874 6.(c) If alive, give age..... years
 8. AGE: Years..... 74 Months..... 1 Days..... 15 If less than one day..... hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 31 August 19 48 at 3:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
18 June 19 48 to 31 August 19 48
 and that I last saw him alive on 31 August 19 48

Immediate cause of death.....
Carcinoma of cervix uteri

DURATION

Due to..... pyelonephritisDue to..... Cachexia

Other conditions..... Cystitis; Anemia; Septic Spleen
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results..... confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Paul Peterson
PAUL PETERSON, Captain MC USN
 M. D. or other

Address..... USNH Bethesda, Md. Date signed..... 8-31-48

9. Birthplace..... Virginia
 (Town, county, and state)
 10. Usual occupation..... housewife
 11. Industry or business.....
 12. Name..... DaVal, Vinton dec
 13. Birthplace..... Md.
 14. Maiden name..... SMITH, Augusta dec
 15. Birthplace..... Md.
 16. Informant..... son: Cdr. Vincent C. Tompkins USN
 Address..... 7406 Shirland Avenue, Norfolk, Va.
 17. cremation Date thereof..... 9-1-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Ft. Lincoln
 Location..... Washington, D.C.
 18. Funeral director..... Gasch Sons E.G.
 Address..... Hyattsville, Maryland
 19. 8-31 19 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

08540

132

1. PLACE OF DEATH:

County Bethesda (rural)
 City or town Montgomery
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Kansas County _____
 City or town Manhattan
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 309 Bierre Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war W.I.I.

3. (a) FULL NAME

WEAVER, Glenn Wallace

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Mrs. Barbara Weaver
 7. Birth date of deceased (mo., day, yr.) April 19, 1907 6. (c) If alive, give age _____ years
 8. AGE: Years 41 Months 4 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Kansas
 (Town, county, and state)
 10. Usual occupation Stell Worker
 11. Industry or business _____
 12. Name WEAVER, Taylor dec
 13. Birthplace Mo.
 14. Maiden name STRANGE, Cora
 15. Birthplace Mo.

16. Informant wife: Mrs. Barbara Weaver
 Address 309 Bierre St., Manhattan, Kansas
 17. burial Date thereof Aug. 27, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Louisville Cemetery
 Location Louisville, Kansas
 18. Funeral director W. W. Chambers
 Address 1400 Chapin St., N. W., Wash., D.C.
 19. 8-26 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 August 19 48 at 1:30P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 August 19 48 to 25 Aug. 19 48
 and that I last saw him alive on 25 August 19 48
 Immediate cause of death uremia - chronic
slowly progressive for
Polypytic kidneys, bilat -
 Due to _____ DURATION 1 yr.
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE John A. McEllar, Jr., Lt. MC USN
 M. D. or other _____
 Address US NH Bethesda, Md. Date signed 8-26-48

RECEIVED

AUG 28 1948

BUREAU V. S.

RECEIVED

AUG 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1242 08547

1. PLACE OF DEATH:

County Montgomery
 City or town Olney, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital, Inc.
93 days.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Gaithersburg
 (If outside city or town limits, write RURAL and give nearest town)

Street No. R. # 3 Etchison
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mr. Malcolm DeWitt Weber

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single.

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 6, 1896 6.(c) If alive, give age.....years

8. AGE: Years 52 Months 4 Days 8 If less than one day
 hrs. min.

9. Birthplace Montgomery Co. Maryland
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Remus G. Weber13. Birthplace Maryland14. Maiden name Emma F. Burdette15. Birthplace Damascus, Md.16. Informant Hospital records

Address

17. Burial Date thereof August 17-1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Damascus Cem.Location Montgomery, Md.18. Funeral director Ray W. BarkerAddress Washington, Md.19. Aug 16, 1948 Scitrus B. Lawler

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14, 1948 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 12, 1948 to August 14, 1948and that I last saw him alive on August 14, 1948Immediate cause of death CachexiaDURATION 1 mo.Due to Cirrhosis of liver 18 mo.

Due to

Other conditions Rheumatoid Arthritis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. H. Higon, M.D.

M. D. or other

Address Sandy Spring, Md. Date signed 8/14/48

RECEIVED

AUG 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age in correct place. Indicate cause of death clearly and legibly. is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08542
416

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) if veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof.

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19. 48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed

RECEIVED

SEP 7 1948

BUREAU, V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery
 City or town..... Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 22 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution?..... 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C. County.....
 City or town..... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1413 37th St., N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... WWI ✓

3. (a) FULL NAME

WESTLEIN, Joseph Clifford

3. (b) Social Security Number

4. Sex..... male
 5. Color or race..... W-US
 6. (a) Single, married, widowed, or divorced..... married

6. (b) Name of husband or wife..... Marie R. Westlein

7. Birth date of deceased (mo., day, yr.)..... 30 July 1894
 6. (c) If alive, give age..... years

8. AGE: Years..... 54 Months..... 1 Days..... 0 If less than one day..... hrs. min.

9. Birthplace..... Nebraska
 (Town, county, and state)

10. Usual occupation..... Taylor11. Industry or business..... Public Works12. Name..... WESTLEIN, Frank dec.13. Birthplace..... Wis.14. Maiden name..... GOLDSBERRY, Marie dec.15. Birthplace..... Neb.16. Informant..... wife: Mrs. Marie R. WestleinAddress..... 1413 37th St., N.W., Wash., D.C.

17. burial Date thereof..... 9-2-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington NationalLocation..... Arlington, Virginia18. Funeral director..... W. W. Chambers RKSAddress..... Georgetown, D.C.

19. 8-31 19 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 30 August 19 48 at 3:05P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
8 August 19 48 to 30 August 19 48
 and that I last saw him alive on 30 August 19 48

Immediate cause of death.....
Uremia, underlying cause:
Hypertensive Heart Disease & Cerebral Infarct
 Due to..... Hypertensive Heart Disease indef.
Cerebral Infarct indef.
 Due to.....
 Other conditions.....
 (Include pregnancy, within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

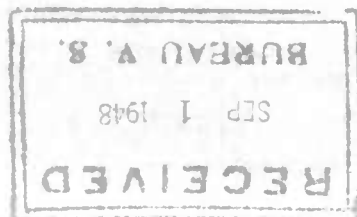
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... injured at work?

23. SIGNATURE..... Martin COOPERMAN Cdr. MC USNAddress..... USNH Bethesda, Md. M. D. or otherDate signed..... 8-31-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 08544
216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since 8-3-48Hospital, institution, or street address where death occurred: Suburban Hosp.8600 Old Georgetown Rd. Bethesda Md.How long in hospital or institution? Since 8-3-48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____City or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 2822 Devonshire Place

(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Anne L. Whalen

3. (b) Social Security Number

none

4. Sex

F

5. Color or race

White

6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband Arthur R. Whalen (Deceased)

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Aug. 21, 1898

8. AGE:

Years

Months

Days

If less than one day

541118

hrs.

min.

9. Birthplace

Wakefield, Mass.

(Town, county, and state)

10. Usual occupation

Claims Examiner

11. Industry or business

FATHER

12. Name

Eugene Hennars

13. Birthplace

Hungary

MOTHER

14. Maiden name

Anne Mc Auliffe

15. Birthplace

Mass.

16. Informant

Eugene F. Fairbanks

Address

2822 Devonshire Pl., N.W., Wash., D.C.

17. Burial

Date thereof Aug. 11, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rock Creek Cemetery

Location

Washington, D. C.

18. Funeral director

Warrar E. Pumphrey, Inc.

Address

8434 Ga. Ave., Silver Spring, Md.

19.

(Date rec'd by registrar)

8/10 1948Wm E. Golder

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1948 at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 28, 1948 to Aug. 9, 1948and that I last saw him alive on Aug. 8, 1948

Immediate cause of death

Uremia, due to

DURATION

3d.

Due to

Malignant hypertension2 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work? _____

23. SIGNATURE

W. H. McGrail M.D.
Silver Spring, Md. Date signed 8/9/48

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County _____
 City or town Alexandria
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1624 Abingdon Drive
 (If rural, give LOCATION)
 2. (a) If veteran, name war WWI

3. (a) FULL NAME

WOMACK, Robert Howard

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mrs. Goldie E. Womack

7. Birth date of deceased (mo., day, yr.) September 20, 1888 6. (c) If alive, give age _____ years

8. AGE: Years 59 Months 10 Days 33 If less than one day _____ hrs. _____ min.

9. Birthplace Mo.
 (Town, county, and state)

10. Usual occupation Civil Service, Agriculture Dept.

11. Industry or business

12. Name WOMACK, Robert dec.13. Birthplace La.14. Maiden name MEGOWN, Sue E.15. Birthplace Mo.16. Informant wife: Mrs. Goldie E. WomackAddress 1624 Abingdon Dr., Alexandria, Va.

17. burial Date thereof Aug 4, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Francis Memorial ParkLocation Flat River, Mo.18. Funeral director W. W. Chambers & Co.Address Georgetown, D. C.

19. 8-3- 19 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH 3 August 19 48 at 5:20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 July 19 48 to 3 August 19 48 and that I last saw him alive on 3 August 19 48

Immediate cause of death Bronchopneumonia DURATION 72 hrs.

Due to Bronchogenic carcinoma with metastases to lymph nodes

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

W. F. Queen
Wm. F. QUEEN, Cdr. MC USN

23. SIGNATURE Wm. F. QUEEN, Cdr. MC USN
 M. D. or other 8-3-48

Address USNH Bethesda, Md. Date signed _____

80

